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UNRRA Takes Command

In the midst of the most devastating war in history, an amazing international organization for relief and rehabilitation has been planned and is already under way. Never before has there been a more striking demonstration of the conflict between the opposing forces which sway mankind — on the one hand, the devouring lust to kill and to destroy, on the other, the unquenchable desire to protect and to heal.

It is only within the last few months that there has been much publicity concerning the United Nations Relief and Rehabilitation Administration, familiarly known as UNRRA, but the initial thinking and planning must have been going on in many minds in many countries for a long time. All this activity culminated recently in a meeting held in Atlantic City at which the representatives of 44 nations were present. The British Commonwealth of Nations, the United States of America, China and Russia, are jointly responsible for leadership, but the smaller nations control certain indispensable resources and are therefore in a position to exercise considerable influence.

The factor of urgency seems to be a potent driving force in the affairs of UNRRA and is overcoming the fatal tendency to postpone action that paralyzes so many humanitarian projects. UNRRA is planning to meet post-war needs — yes, but to do much more. It is already moving in behind the lines, close up to the fighting fronts, and stands ready to take over in the liberated countries as soon as ever the armies move forward. There will be no waiting for the guns to cease firing. UNRRA is on the job, here and now. There is the dream but there is also the business.

As a matter of fact, UNRRA quite literally *is* a business. Relief is not to be handed out on a platter to all and sundry. Those who need it most will get it first and as speedily as possible. But its distribution and administration

will be in the hands of skilled persons who know how to handle large-scale enterprises. When the need is overwhelming (as in Greece) relief will be given outright but, whenever possible, some return will be expected. In many instances there will be a combination of gift and commercial obligation. For example, large quantities of wheat may be delivered promptly and paid for, in part, when times are better. UNRRA realizes that enormous free gifts, either in money or kind, might throw the economic system of a country off balance and thus do more harm than good.

All kinds of commodities are to be made available. Devastation in some areas is so complete that nothing remains and everything must be provided. Food is the primary and immediate need, and will be met first, although there is much else that is almost as important. Fertilizers to restore the scorched earth, seeds, farm machinery, fuel, fishing equipment, draft animals, all must be forthcoming, and quickly.

Where are all these necessities to come from? It lifts the heart and fires the imagination to know that they will come from the United Nations themselves. All of them, large and small, are pledged to carry this magnificent task to completion, no matter what the cost in money, sacrifice and effort.

What has Canada to offer? Gifts that are uniquely her own and that come from her soil, her rivers and her seas. A golden flood of grain, milk for starved children, the best meat and fish in the world, fruit in abundance. No need now to burn wheat (God forgive us!) or dump carloads of rotting apples into Lake Okanagan, or to waste our substance in any other shameful way while people go hungry. UNRRA will see to it that the balance is held even.

There is another need that UNRRA seeks to fulfil and that comes very close to us. Carefully selected people will be required to carry out rehabilitation measures, especially those which are directly related to public health and medical and hospital services. At this point it seems pertinent to quote from an address made recently by Philip Jessup: "No organization, whether national or international, is any better than the human beings who operate it. If they are inadequate and unskilled, if they are falsely motivated, the best constructed organization will fail". Mr. Jessup contends that untrained personnel should not be sent abroad. But he also makes it clear that workers must be assigned to the field as rapidly as possible and that "there is no time to luxuriate in months of academic training".

Mr. Jessup also emphasizes the importance of keeping the ratio of foreign supervisory personnel, no matter how well qualified, as low as possible. The people who will do the bulk of the work (and the best of it) are the people of the country itself. In the American Relief Administration, which did such magnificent work after the first World War, one American was used to every thousand local people. But that one American had to be mighty good!

While not attempting to impose any hard and fast rule, Mr. Jessup has quite definite opinions about the sort of people who ought to be selected for service abroad. He thinks that they must have maturity and balance and, all things being equal, be between 25 and 55 years of age. They must possess physical stamina and resilience for, as Mr. Jessup reminds us, "don't forget that relief is administered under hard physical and mental strain".

Suppose *you* can measure up to the high standard set by UNRRA, how should you prepare for the high adventure? Begin by reading everything you can get hold of about the countries to which you may be assigned. Start right now to learn French and German, especially German. Don't try to learn them

out of books. Find a teacher who speaks the language fluently and makes you speak it. Brace yourself to endure loneliness, misunderstanding, jealousy and intrigue. Above all, remember that the people to whom you go are just as civilized as you are and perhaps more so. Be willing to learn from them before you presume to direct them.

—E. J.

The Facilitation Process and Venereal Disease Control

LIEUT.-COL. D. H. WILLIAMS, R.C.A.M.C.

The acquistion of venereal disease is comprised of two component parts, firstly, the source or infected individual and, secondly, the circumstances whereby the source is made accessible to the once healthy person. Based upon this dual concept of acquisition, control efforts logically consist of two steps — action dealing with the source, and action directed toward the removal of conditions rendering the source accessible. It is with the problem of accessibility of sources of syphilis and gonorrhoea that this presentation is chiefly concerned. To this phase of the acquisition of the venereal diseases the term "facilitation process" has been given.

The facilitation process comprises those community conditions associated with the direct or indirect, witting or unwitting participation, usually for monetary gain, of third persons whereby individuals sufferings from communicable venereal disease are made accessible for intimate exposure to healthy persons. The facilitation process centres chiefly around those community fornicatoriums known commonly as disorderly houses, and is associated also with certain beer parlours, hotels, dance halls, taxicab companies, rooming houses, apartment blocks, massage parlours, tourist camps, roadhouses and restaurants. The "facilitators" or third-person participants are "madams", pimps and procurers, with whom are closely associated certain physicians, lawyers, finance companies and real-estate agencies. Less obvious, but definitely in the ranks of the facilitators, are the managers and owners of premises which facilitate healthy individuals toward sources of gonorrhea and syphilis. The attitude of certain civic administrations, health departments and law-enforcement agencies who condone community conditions which year after year facilitate large numbers of each new generation toward venereal infection and ill health, places the officials in these administrations in particular, and the public in general, in the position of being facilitators. Last but by no means least among the facilitators are those engaged in the commerce of alcohol for oral administration. Alcohol is the lubricant of the facilitation process.

The facilitation process differs in its nature and extent in every community. The process can be accurately and quickly investigated and assessed by a

careful study of that aspect of the acquisition of infection by each new patient with gonorrhoea or syphilis pertaining particularly to the means whereby the patient, once healthy, found access to the source of his ill health. A person with a recently acquired gonorrhoeal or syphilitic infection is a most valuable public health asset. This paradox may seem startling but it is nevertheless true. Throughout our communities run the ever ramifying, ever multiplying threads of venereal infection. The patient with a recent venereal infection has touched that hidden network somewhere; that is why he is ill; that is why he is seeking help from his physician. This patient has information which can initiate action that will expose a portion of the mesh to the wholesome light of modern medical science and public health influence.

The patient's physician likewise can be an accessory to this beneficence. It all hinges upon the physician's earnestly, diligently, painstakingly seeking information from the patient regarding the source and the circumstances concerned in the acquisition of his infection. Upon the accuracy and detail of the information provided depends the success of appropriate agencies in protecting the health of the community against specifically named sources and community conditions promoting the spread of venereal disease. It requires time and patience on the part of the physician and confidence on the part of the patient. The information cannot be obtained by blunt questioning. Complete privacy during the interviews is essential. Compelled by a strong personal sense of responsibility, aware of the confidential handling of information by the health department, certain that his identity will not be revealed, and assured that the source of his infection will not be embarrassed but will be approached by a health department worker, discreetly, with kindness and from the standpoint of the source's personal health, the patient under these circumstances usually will tell the truth in complete detail.

As far as the source is concerned, the name and the address are the keys to the investigation. If not obtained on first questioning, a second and third talk should be tried. The skilful building up of responsibility in the mind of the patient often, in a day or two, will end in the complete story. An answer about "being too drunk to remember" given as a first reply frequently covers personal reticence and a desire to protect the identity of the source. Repeated sincere questioning often elicits the name and address. When source information has been obtained the investigation should proceed to reveal whether facilitation was associated with the exposure or not. In many instances no facilitation coexists. Was the exposure free from mercenary participation in the relationship of a third party? Where information regarding the source is scanty or lacking, details concerning facilitation may prove of paramount value. Detailed information concerning the source, in the possession of the expert health-department epidemiological worker, will result in many sources being found and placed under proper care. Immediate efforts should be made to find the source.

Wherever and whenever a source is found, he or she must be treated as a human being that needs medical care, kindness and often social and economic assistance. The attitude of the health department should not savour of condescension, convey an implication of broken moral codes, or smack of infracted criminal statutes. Too often and too long have we permitted the term "suppression of prostitution" to crack the whip of community legal action against unfortunate, unhealthy women, harrassing and badgering them into further depths of underworld subjection and personal abjection, while those facilitators who have lived off the earnings of these sick women have not felt the sting

of public indignation and the welts of restraining law enforcement. The community should suppress facilitation rather than prostitution.

The role of the health department in directing action against the facilitators and facilitation process is a relatively limited but nevertheless important one. On the basis of information obtained from patients suffering from recent venereal infection, the health department's duty is to arouse the personal consciousness of the facilitators in their participation directly or indirectly, wittingly or unwittingly, in the spread of venereal disease. The health department should point out the seriousness of the situation and the need for removing the facilitation. The department on the basis of its experience may even advise the facilitator of the best means of effectively and expeditely dealing with the facilitation. The burden of action itself, however, should not be carried by the health department. The responsibility lies with the facilitators themselves, and with appropriate community agencies concerned with the particular type of facilitation under consideration; agencies which are empowered through laws and by-laws in every community to deal with the specific phases of facilitation concerned.

Much can be accomplished on a voluntary basis. Suasion and voluntary cooperation are always preferable to force and legal action. The latter should be a last resort. Personal interview by two senior members of the health department, confirmed immediately in writing, outlining diplomatically the health problem and the associated facilitation, is the first step. Incorporated in the conversation and subsequent correspondence should be suggested means for reducing the facilitation. Where a man in the Armed Forces or in war industry has been infected, the reduction in the efficiency of the war effort should be emphasized. This approach in the final analysis actually represents personalized venereal disease education. The education is applied strategically where it is most valuable.

The sincere, co-operative facilitator, usually unwittingly associated with the facilitation, will immediately do everything in his power to assist. Indeed, this type of person often becomes a tower of strength behind the scenes for the health department. Where insincerity exists, the continuance of facilitation produces with each new infection an increasing number of interviews and confirmatory correspondence, the cumulative weight of which often effects the badly needed action by the facilitator. Where this fails, the seriousness of the continuing threat to the public health is such that the health department in its line of duty must discuss the matter with, and send copies of the confirmatory correspondence to, the senior health officials, appropriate licensing boards, law-enforcement agencies and other civic administrative departments whose laws and by-laws are directed against the specific type of facilitation concerned. Where co-operation and mutual understanding between the health department and facilitator fail, cancellation of the licences of offending premises such as rooming houses, massage parlours, hotels, beer parlours, taxicab companies and dance halls, stiff fines for landlords and real-estate agencies, and lengthy jail sentences for the madam, the pimp and the procurer, have a most salutary effect.

Having discussed in general terms the subject of facilitation, it is the purpose of this presentation to relate specifically the experience of the Vancouver Clinic, Division of Venereal Disease Control, Provincial Board of Health, British Columbia, concerning source finding and the facilitation process in the Greater Vancouver Area. A detailed study has been made of the acquisition of gonorrhoea and primary syphilis by adult male persons admitted

TABLE 1

RESULTS OF INVESTIGATION OF FEMALE SOURCES OF 884 MALE GONORRHOEAL AND 55 MALE PRIMARY SYPHILITIC INFECTIONS ADMITTED TO THE VANCOUVER CLINIC DURING 1940 AND 1941

	Investigation of Acquisition of Infection	Type of Infection	Number of Infected Males	Female Sources Found	
				Number	Per cent
A	Source of Information Unavailable	Gonorrhoea	176	—	—
		Syphilis	11	—	—
		Totals	*187*	—	—
B	Source of Information Available	Gonorrhoea	708	191	27
		Syphilis	44	11	25
		Totals	*752*	*202*	*27*
	1. Facilitation Involved	Gonorrhoea	276	47	17
		Syphilis	25	3	12
		Totals	*301*	*50*	*17*
	2. No Facilitation	Gonorrhoea	432	144	33
		Syphilis	19	8	42
		Totals	*451*	*152*	*34*
	Totals (A and B)	Gonorrhoea	884	191	22
		Syphilis	55	11	20
		Totals	*939*	*202*	*21*

to the Vancouver Clinic. The source and facilitation process were investigated in each instance. The results of efforts firstly to find the sources of these infections, secondly to determine the nature of the facilitation, and thirdly to direct action against the associated facilitator, are presented, along with the gratifying early evidence of reduced venereal disease. In every instance the greatest possible care was taken to differentiate the actual source of an infected patient from other contacts. This was obviously more difficult in the case of syphilis, but where any doubt existed concerning an alleged source, the individual was not listed as a source.

In table 1 are shown the results of investigation of the female sources of the 884 male gonorrhoeal and the 55 male primary syphilitic infections admitted to the Vancouver Clinic during the years 1940 and 1941. The preponderance of gonorrhoeal as compared with syphilitic infections is immediately evident. The much greater number of gonorrhoeal infections as compared with that of syphilis demonstrates the greater opportunity to gain information regarding facilitation in the area from a study of gonorrhoea than from syphilis. The value of the volume of evidence based on numbers of infected patients and its cumulative effect in establishing a case against facilitators and facilitation is evident. Conversely, interest in venereal-disease control limited to syphilis alone would render incom-

plete and hazy any true picture of facilitation in the Greater Vancouver Area and as a result provide no clear-cut evidence upon which to support action against the facilitation process. The gonorrhoea-to-syphilis ratio of 16 to 1 suggests the likelihood of the presence of considerable undetected male primary syphilis in the community.

From the standpoint of source finding the results are not wholly gratifying. This very fact, however, gives weight to the importance of attention to the facilitation phase of the acquisition of the infections. Where source finding fails, anti-facilitation action often will save the day. For the 884 male gonorrhoeal infections, 191 sources (22 per cent) were found. Of the 55 instances of male primary syphilis, 11 sources (20 per cent) were found. It is of interest to note the close correlation between the percentage of sources found for the two types of venereal infection. Generally it is believed that source finding in syphilis is less successful than it is with gonorrhoea. These figures do not support this contention. A striking correlation will be observed throughout table 1 when gonorrhoea and syphilis are compared from various standpoints. For example, there is a complete lack of information regarding the source in 20 per cent of each infection group. Although only one-fifth of the sources were found, the value of the detection and adequate care of 191 persons with gonorrhoea and 11 with early, highly communicable syphilis on a basis of their actual and potential danger to the community cannot be considered by any means a small public health gain.

In the infection of 708 men with gonorrhoea, facilitation played a contributory role in 38 per cent or 276 instances. Analysis of source finding on the basis of whether facilitation existed or not demonstrated a striking difference in the effectiveness of source finding under the two circumstances. In 432 cases where there was no facilitation 144 or 33 per cent of the sources were found; whereas, in 276 instances where facilitation occurred only 47 or 17 per cent were detected. The figures for syphilis, though smaller in number, corroborate this disparity to an even greater extent. These findings generally confirm the difficulty which health departments encounter in locating the sources of infection associated with facilitation. It is this very type of source which it is most important to detect because of the number and diversity of her exposures. It is obvious from the study that the results are rather unsatisfactory in this group. This very fact originally initiated the indirect strategy focussed upon facilitation. Often where information regarding the source was partially or completely effaced by the influence of alcohol, facts concerning the facilitation were remembered.

Investigation of the facilitation process revealed that it centered chiefly around tolerated, illegally-operating disorderly houses, certain beer parlours, a dance hall, several rooming houses and cheap hotels. It became apparent that these premises wittingly and unwittingly, directly and indirectly, were facilitating healthy men toward intimate exposure to women infected with gonorrhoea and syphilis. In the two years referred to in table1, 276 male gonorrhoeal infections and 25 male primary syphilitic infections were associated with facilitation. The comparative figures for gonorrhoea and syphilis are noteworthy. This comparison demonstrates the relatively small, almost negligible evidence that would have been built up against facilitation in the Greater Vancouver Area in the two-year period if the Vancouver Clinic had interested itself only in syphilis. The action based on numerically impressive evidence provided by the investigation of facilitation in the acquisition of gonorrhoea could never have been developed on the basis of syphilis alone.

TABLE 2

REDUCTION IN MALE GONORRHOEA INCIDENCE OBTAINED BY ACTION DIRECTED AGAINST THE FACILITATION PROCESS INVOLVED IN CERTAIN PREMISES IN THE CITY OF VANCOUVER

Facilitation Premises and Type of Action	Annual Number of Infections from Premises		Percentage Reduction in Infections
	Before Action	After Action	
Disorderly Houses Public Education Law Enforcement	55.5	22.2	60.0
Beer Parlours Cancellation of Licence Partition to Segregate Sexes Co-operation of Brewery Industry	70.3	21.0	71.2
Dance Hall Prohibit Unescorted Women Co-operation of Owner	22.5	6.0	73.3
Rooming House Change of Ownership Co-operation of Real Estate Agency	7.4	0.0	100.0

An interest by the Clinic solely in source finding would have permitted 80 per cent of the sources to continue as a serious actual and potential hazard to the community health. Where facilitation existed, steps were taken to demonstrate the need for action and in many instances the Clinic indicated the type of action which would be most effecitve. The basic principle behind all action was that of making it as difficult as possible for apparently healthy men to meet potentially infected women. In table 2 are shown four examples of facilitation premises, indicating the type of action directed against the facilitation and the results in reduced incidence of male gonorrhoea following the action. A very striking reduction is seen in every instance. The suppression of disorderly-house facilitation was accomplished largely by effective newspaper publicity, widespread, intensive public education and the enforcement of sections of the Criminal Code of Canada, especially those sections directed against the landlord and rental agencies. The action in connection with facilitation in beer parlours in Vancouver consisted of the cancellation of the licence of one parlour by the British Columbia Liquor Board and by compulsory partitioning of all premises, so that each premise was divided into two sections. One section admitted men only, and the other, women or women escorted by men. The need for this segregation was concurred in by the brewery interests who are anxious to dissociate their business from the facilitation of venereal disease.

Investigation of facilitation in dance halls revealed that it was associated overwhelmingly with one hall. In most instances the healthy males had met the

sources of their infection in this dance hall. The sources were as a rule unescorted women. The management was very co-operative, and agreed voluntarily to refuse admission to unescorted women. Immediately this action was taken, the incidence of venereal disease associated with facilitation in the premises fell abruptly. It was interesting to note that coincident with this reduction, there was no reciprocal increase in facilitation in other dance halls in the city.

The example of the rooming house referred to in table 2 is typical of a number of premises in the same facilitation category. The owners of such premises generally were unaware of the venereal disease facilitation of their properties. The rental agencies were undoubtedly in some instances well aware of the use of the premises for purposes of prostitution but had not been conscious of the concomitant venereal disease dispensing that went on as an integral part of the prostitution. Knowledge of the latter gave them real concern. In the instance recorded in table 2, the real-estate company immediately sold the property for the original owners. Since then not a single instance of venereal disease has been associated with the premises. In general it may be stated that, whenever facilitation was evident in the Greater Vancouver Area, the Division discreetly and diplomatically made the facilitators aware of their participation. With the exception of the operators of disorderly houses, the facilitators have been co-operative.

Conclusions:

1. The venereal diseases are largely the by-product of community conditions which facilitate the intimate exposure of healthy persons to infected ones.

2. The witting or unwitting, direct or indirect participation, often for monetary gain, of third persons known as facilitators in rendering persons with communicable venereal infection readily accessible to healthy persons is known as the facilitation process.

3. The nature and extent of the facilitation process in any community can be determined by a detailed investigation of individuals suffering from recently acquired infections and amassing information not only concerning their sources but relating particularly to the circumstances whereby access was gained to these sources.

4. On the basis of cumulative evidence, resulting from investigation of the role of facilitation in the acquisition of recent venereal infection, the duty of the health department is to arouse the consciousness of the facilitators of their participation in the spread of venereal disease and to indicate to these facilitators the need for them to initiate and direct action to eliminate that phase of the facilitation process with which they are associated.

5. The action directed against the facilitation process depends upon the nature and extent of the facilitation and upon the attitude of the facilitator. Where sincerity and voluntary co-operation are lacking, the coercive and deterrent effect of enforcement of specific laws and by-laws may be necessary.

6. Energy expended in the suppression of facilitation in a community is far more profitable from the public health standpoint than the usual misdirected efforts at suppression of prostitution which harass the exploited unfortunate, sick prostitute and leave untouched the exploiting, wealthy, healthy facilitator.

7. In the Greater Vancouver Area, the Vancouver Clinic, Division of Venereal Disease Control, Provincial Board of Health, British Columbia, during the years 1938 to 1941 inclusive, determined the nature and extent of the facilitation process in the area and revealed this process in its true light as a principal contributing factor in the spread of venereal disease in the area.

8. The direction of appropriate action against the facilitation process in the Greater Vancouver Area has resulted in an early gratifying evidence of reduced venereal disease incidence in the civilian and resident military population in the area.

Editor's Note: This article appeared in the September 1943 issue of The Canadian Journal of Public Health and is reprinted with the kind permission of the editor. Owing to lack of space, it has unfortunately been necessary to omit certain paragraphs but an effort has been made to preserve the force and continuity of the original.

The Royal Canadian Naval Nursing Service

The time has not yet come to tell the glorious story of the Royal Canadian Navy. True to its inherited honourable tradition, it is "the Silent Service". Yet, every now and then, there comes a tale of courage and sacrifice that stirs the blood and fires the imagination. Canada goes down to the sea in ships — fighting ships and fighting men.

The Royal Canadian Naval Nursing Service is fast leaving its infancy behind and is on its way to maturity. During the war from 1914 to 1918 there were only five Naval Medical Officers serving in the R.C.N. all of whom left the Service when the Navy underwent drastic reduction. Continuity was maintained, however, through the intervening years, in the R.C.N.V.R., and the beginning of this war found a nucleus of six Medical Officers. The services of Nursing Sisters were therefore not a necessity until the erection of the first Naval Hospital.

Photo by John S. Steele

MARJORIE G. RUSSELL, A.R.R.C.

Organized in December, 1941, the Nursing Service began with the small number required to fill the needs of the then three new Naval Hospitals. At that time a large Nursing Service was not visualized, but with the rapidly increasing Naval personnel (there are now 350 Medical Officers) it has assumed proportions exceeding any expectation and is now a thriving body with an arm across the sea at our one Naval Hospital in the United Kingdom.

The Matron-in-Chief of the R.C.N. Nursing Service is Marjorie Gordon Russell, the first nurse to serve in this distinguished capacity. Miss Russell was born in Central India and was educated in Northern Ireland. She is a graduate of the School of Nursing of the Hospital for Sick Children in Toronto, and has had considerable experience in administration and supervision while holding responsible positions both on the staff

Royal Canadian Naval Photo

Box for treatment of "immersion foot"

of her own Hospital and the Montreal General Hospital.

Unlike the Medical Officers, who serve in ships of both the Royal Navy and the Royal Canadian Navy, and as there have been no Canadian Naval Hospital Ships up to the present, Nursing Sisters are for service in shore establishments only. On entry, a rtaining in Service routines and documentation is given, added to which is a small amount of physical training. Instruction in the various departments which have been equipped with every device for use in ships makes it all intensely interesting. Recently permission has been granted for a day at sea in a ship of war, which is most informative and greatly enjoyed. To appreciate the living conditions of the sailor, his quarters, the nature of his work and his hazards is an essential, if one is to understand whom one is to nurse. It is, of course, not possible to gain all this knowledge in one day of seafaring, but at least an insight is obtained which adds greatly to the skill of the Naval Nurse.

Nursing Sisters, who are fully qualified instructors, give courses of lectures to sick berth attendants who assist in the care and treatment of the patients. The larger hospitals have, besides the various departments necessary to a general active hospital, a central surgical supply room which facilitates efficiency and saves equipment which in many cases it is now difficult to replace.

As well as registered nurses, the Nursing Service embraces dietitians, physiotherapists, occupational therapists, laboratory technicians, and home sisters. These departments are a necessary part of the treatment and rehabilitation of the men in the Service.

Qualifications for a Nursing Sister are that she be a British subject, a graduate of a School of Nursing accredited by the Canadian Nurses Association, and registered in a Provincial Association. She must be under 35 years of age and passed as medically fit. It might be stated here that the number wishing to serve far exceeds the demand, there being enrolled at present some 230 out of ten times that number of applications. Applicants are selected on their training, subsequent experience and personality and all credit is due to Surgeon Captain A. McCallum, the Medical Director General of the R.C.N., for fostering this service so successfully.

With a desire for uniformity in the

Royal Canadian Naval Photo

A Naval Nursing Sister gives instructions to sick berth attendants

Canadian Nursing Services, so that they might be recognized as such anywhere, the uniform was made similar in style to that worn by the Nursing Service of the R.C.A.M.C., differing in detail as to colour and insignia. The dress is very appropriately navy blue, with gold lace and maroon distinction cloth denoting the rank and service on the shoulder straps; (green cloth is worn by dietitians, physiotherapists, etc.) The gold buttons with crown and anchor are not polished but allowed to develop a "salty" distinction, as is the Naval buckle on the black belt and the officer's cap badge worn on the hat. There is the usual great coat and, for dress occasions, a cape enhanced by an old-gold lining. For duty in hospitals the approved uniform is the copen blue twill dress with white, square-cut apron, stiff white collar and cuffs and, of course, the organdy veil. Beige stockings and black shoes are worn. In all, a most attractive ensemble.

On several occasions, nurses have accompanied patients by air or rail to some destination required in the pursuit of their return to health, or they have gone to assist in the treatment of patients in emergency. At the time of the disastrous fire in the Kiwanis Hut in Newfoundland a year ago, the Nursing Sisters displayed their skill in such a manner as resulted in the speedy and efficient treatment of the many injured.

One Nursing Sister, Miss Agnes Wilkie, lost her life in the sinking of the "Caribou" by torpedo attack, in spite of the valiant effort of Sister Margaret Brooke (dietitian), who for her deed of valour was subsequently awarded the O.B.E.

There is much that could be said, much that has been seen, as a result of the Battle of the Atlantic, the Carribean, the Mediterranean and other scenes of action, but this must await another day. In the meantime, the pursuit of peacetime nursing, as embodied for instance in the well baby clinic which is a flourishing part of the Naval Hospital at Halifax, is a subject of much interest. It is hoped a story about this may appear in a later edition of *The Canadian Nurse*.

Multiple Myeloma

RUTH BLACKWOOD

In presenting this case study of multiple myeloma, something should first be said about the nature of the disease so that when the signs and symptoms are mentioned the reader may more readily understand how the diagnosis was made. Multiple myeloma is a form of tumour and develops in the red bone marrow of the ribs, the skull, the spine, the pelvis, and the upper end of the femur. Fortunately, it is a rare disease as it is always fatal.

A case described in medical literature in 1845 mentioned that a Dr. Bence-Jones had examined the urine of the patient and discovered the proteins which have since been found in approximately 65 per cent of the cases. These are now known as the Bence-Jones proteins. Multiple myeloma occurs most frequently in males and usually between the ages of 40 and 70. Cases have been reported from nearly every country as well as every race and there seems to be no one race or people who are more readily affected than others. Very little is known of the cause or causes and, because of the scant reports from previous cases, there has been difficulty in getting a true picture. In some instances, it has been noted that other members of the patient's family have died of multiple myeloma and there have also been reports of anemia and pathological fracture. Trauma has been mentioned frequently but is usually reported as occurring so early that it is probably of little significance. There have also been cases in which influenza, malaria, or typhoid fever were thought to be the cause but when the wide spread of these infections was taken into consideration it was thought unlikely that they were important factors.

Pain is usually the first symptom and seems to run a typical course, increasing in intensity following some incident such as the sudden jolt of a train. The next stage is occasional pain which gradually subsides until there is a period, lasting from several months to a year, when the patient is almost free from pain. During the last stages of the disease the pain increases until shortly before death it becomes very severe.

Tumour formations may be noticed either before or after the pain occurs, and their number and distribution is important in diagnosis. These tumours vary in size from a pin-point to the size of an orange but are usually about the size of a pea. The patient's attention is drawn to them by tenderness, the presence of a lump, pathological fracture, or a pulsatory sensation. When the ribs are affected, there is often a peculiar sound like paper rustling, which can be heard through the stethoscope. The bones seem to give a sensation of fragility. These tumours are frequently found to increase or to decrease in size and sometimes even to disappear and reappear; this is thought to be due to haemorrhage followed by absorption and to be related to the vascular quality of these tumours; this is also the explanation of the pulsation.

The next sign is deformity. Along the ribs, near the sternum, small tumour nodules form in about 50 per cent of the cases; this condition is known as the "parasternal rosary". Collapse of the vertebrae, resulting from incomplete fractures, may cause kyphosis. The characteristic posture follows these deformities of the spine; the patient stands with his feet placed wide apart, the abdomen protruding, the lower ribs resting on the hips, and the shoulders braced and walks with great care and delibera-

tion. Pathological fractures frequently occur, usually in the ribs. Pulmonary complications often develop and sometimes prove fatal. Gastro-intestinal disturbances include nausea, vomiting, loss of appetite, colicky pains, diarrhea, and lack of free hydrochloric acid. Paralysis sometimes develops when the spine is involved but, apart from some mental confusion late in the disease, the mind remains clear.

The kidney changes are numerous and in nearly all instances the presence of Bence-Jones proteins is noted. These proteins are found by heating the urine to 50 degrees Centigrade, when a white precipitate appears. On further heating to 90 degrees Centigrade, this precipitate disappears and reappears on cooling. The blood changes are varied but there is usually a picture of anemia. Metastases may occur in any part of the body. The x-ray shows the tumours as rounded, punched-out areas of bone destruction; in the skull these mostly appear in the frontal and parietal areas. Biopsy is important for diagnosis. The cells show under the microscope as round, oval, or egg-shaped with an eccentric nucleus.

The prognosis is unfavourable and patients rarely live longer than two years. Deep x-ray therapy is sometimes used to relieve the pain and heal the fractures. Traction may be employed in fractures to minimize the movement of the part and thus reduce the pain. A high calcium and phosphorous diet with Vitamin D is recommended, together with liver extract and tonics to combat the anemia and loss of appetite. The attitude of the nurse should be cheerful and kind and not too pessimistic.

The case we have had an opportunity of studying was that of a doctor, 64 years of age. His family history showed that his father died at the age of 61 years of a small round-celled sarcoma at the site of an old fracture. The physical history showed that Dr. S. had had a cellulitis of the right arm in 1924 which lasted for six weeks. There was no history of pneumonia, pleurisy, or disease of the glands. About seven months prior to his admission to our Hospital, he developed soreness and tenderness on pressure over a rib near the right axilla. He thought at first that this was due to sitting up suddenly on awaking one morning. The pain was similar to that caused by a fracture but there was no other illness or accident. Apart from the soreness he was quite well, until five months later he noticed increasing loss of appetite, nausea, fatigue, and weakness. There was also occasional vomiting but there were no symptoms of heart, kidney, or chest trouble. He slept well but for about a month suffered from headaches, usually in the frontal area. There was no severe loss of weight and although he was pale he appeared to be well nourished. A swelling was apparent on the ninth rib in the axillary area of the right side. There were some crepitations on inspiration.

On admission, Dr. S. was pale, listless, tired, and very depressed. Being a medical man he had diagnosed his own condition by the discovery of Bence-Jones proteins before he came to the Hospital, and naturally understood the prognosis. The biopsy of the ninth rib was done and the tissue examined revealed multiple myeloma. X-rays of the skull showed numerous small areas of lessened density that had a typical punched-out appearance. The same type of areas were seen along the ninth rib and in the pelvis. Urinalysis revealed nothing remarkable except the presence of Bence-Jones proteins. Blood counts showed a haemoglobin of 80 per cent; R.B.C., 3,850,000; W.B.C., 8,550. The blood urea was 70 mgm. per 100 c.c. and the blood creatinin, protein, calcium, and phosphorus were all elevated.

Dr. S. remained in our Hospital for about two weeks and during that time

we tried to stimulate his appetite with an attractive diet. He was also given dilute hydrochloric acid and Viophate D. For a time there seemed to be some improvement and he was up for a little while each day though he was still very weak. He then went to another city for consultation and about three weeks later was readmitted to our Hospital. During the time he was away he received six deep x-ray therapy treatments. His physical appearance when he returned was about the same as when he left. The crepitations in the right chest were still present and could be heard in the left chest also. An x-ray of the pelvis showed an increase of bony destruction. Urinalysis revealed a trace of albumin and an increase of Bence-Jones proteins. His blood count showed the haemoglobin decreased to 59 per cent; R.B.C., 2,500,000; W.B.C., 3,000. The sedimentation rate, normally 30 mm. in 45 min., was increased to 84 mm. showing the presence of an active infection.

The first few days Dr. S. was comparatively comfortable, being free from nausea for the first time in weeks, but a little later the vomiting began again and he was only able to retain small amounts of nourishment. Several blood transfusions were given but with little effect. On May 11 he began vomiting old blood. Then a slight twitching of the facial muscles developed which increased gradually until there was continual spasm of all the muscles. He lapsed into unconsciousness the next morning and expired early on the following day.

This was the first case of mutiple myeloma that I have had the opportunity to observe yet I gather from the textbooks that I have read that it was a typical case. What made it so difficult for everyone was the fact that our patient, being a doctor, knew from the start what was ahead of him. He had marvellous courage which he never lost and, although he was worried and depressed, he was an inspiration to us all.

Mabel Frances Hersey

On December 21, 1943, the news of the death of Mabel Frances Hersey was received with mingled sadness and relief — sadness at the loss of one for whom we had a deep affection — relief that she was at last released from a long and trying illness. We feel that we have lost a true friend as well as a wise counsellor and we shalll always remember the simplicity and dignity of this woman who was so great and yet so unassuming.

Miss Hersey was born in 1872, in Lucan, Ontario, of Irish-Canadian parentage. In 1902 she entered the School of Nursing of the Royal Victoria Hospital and, shortly after her graduation in 1905, became a member of the operating room staff. Three years later she

Photo by Rice, Montreal

MABEL F. HERSEY, O.B.E., LL.D.

was chosen to be superintendent of nurses, a position which she was to fill with great distinction for thirty years. In the recently published history of the R.V.H. Training School, written by Marjorie Dobie Munroe, the following penetrating comment is made:

> Whatever ambitions Miss Hersey may have cherished for her nursing career that of the superintendency was definitely not one of them. But certain persons, by reason of their capacities and the respect which they command in others, are destined for positions of responsibility and trust. So it was with Miss Hersey. She did not choose the office; it chose her, and, though reluctantly at first, she finally accepted its challenge.

Many changes and developments took place during Miss Hersey's long tenure of office and all were met with great breadth of wisdom and depth of understanding. Every new department opened for the care of patients involved the problem of supplying and organizing the necessary nursing staff. Student enrolment increased and the introduction of new teaching methods, as well as the increased content of the curriculum, kept the School in line with modern conceptions of nursing education. It was largely due to Miss Hersey's influence that scholarships were made available for promising young nurses which made it possible for them to undertake post-graduate work and to return to their own School to teach others.

In this connection, mention should also be made of the important part Miss Hersey played in helping to establish the School for Graduate Nurses at McGill University. Many difficulties had to be overcome, but the university authorities were finally convinced that the School was not only needed by the nursing profession but that it would also prove to be an asset to the University. Miss Hersey served as convener of the advisory committee of the School from 1932 to 1938 and the quality of her leadership was most outstanding. She will also be gratefully remembered for the personal interest she showed in individual students and her generous hospitality to them.

Miss Hersey rendered magnificent service to the many nursing organizations with which she was associated. She held office as president of her own Alumnae Association and, as president of the Association of Registered Nurses of the Province of Quebec, took an active part in obtaining registration for nurses in the Province of Quebec. She even put up her own life insurance policy as collateral to meet legal fees when, in the early days, the Association had little financial backing.

In 1929 the International Council of Nurses met in Montreal and Miss Hersey, in her capacity as president of the Canadian Nurses Association, was hostess to thousands of nurses from all over the world. At that time, a distinguished foreign guest spoke of her as follows: "How wisely you Canadians chose your president for this historic occasion. She has the dignity and strength one expects in a woman holding such an important position and yet possesses the added gifts of simplicity and charm". In 1930, when on leave of absence in England, Miss Hersey was received by Her Majesty Queen Mary at Buckingham Palace and was thanked personally for the generous hospitality extended to British nurses during the I. C. N. meeting.

Like all leaders, Miss Hersey could be a strict disciplinarian, yet those who worked closely with her realized her tolerance and generosity. Her amazing capacity for remembering names and faces was a truly happy gift and here again Marjorie Dobie Munroe has an illuminating comment to make on the secret of her ability to influence people:

> It was not strange that she should be in demand at the conference table or on the public platform. A splendid vitality and the magnetism of enthusiasm carried people with her. She claimed that she had no elo-

quence, and certainly, if the flowery phrase be the criterion, that is true; but if eloquence is when the heart speaks and the tongue delights the ear with the direct word and the humorous touch then Miss Hersey was indeed eloquent.

Many honours were conferred on Miss Hersey in recognition of her outstanding service to nursing but she always regarded them as being paid to her profession and her School rather than to herself. At a beautiful ceremony at Government House in Ottawa she was invested with the Order of the British Empire, conferred on her by His Majesty, King George the Fifth. On this occasion, hundreds of congratulatory letters came to her from all over Canada as well as from abroad.

In 1936, at the biennial meeting of the Canadian Nurses Association, the Mary Agnes Snively Medal, for outstanding service in the nursing profession, was awarded to Miss Hersey, in absentia. A member of her staff accepted the medal on her behalf and one could not help being deeply impressed by the tremendous ovation accorded her by the hundreds of nurses who were present.

The crowning honour came in 1938 when McGill University conferred on her the Honourary Degree of Doctor of Laws. Dr. W. W. Chipman's words, in presenting Miss Hersey to the Chancellor of the University, are worthy of repetition:

> I have the honour to present to you, for the Degree of Doctor of Laws, *honoris causa*, Mabel Frances Hersey, O.B.E. (of the Most Excellent Order of the British Empire).
>
> The health of mind and body is a fundamental need; its attainment a chief aim in any education. In our struggle to survive, this health knowledge is indeed a higher learning, and in that curriculum the Science and the Art of Nursing must always find a place. To this nursing education, Miss Hersey has devoted the years of her working life. She has done much to improve and to extend the service of this great profession. Hers has been a large and signal contribution, already recognized, not only in her own country, but also far beyond our gates. Today, in honouring Miss Hersey and her profession, our University, in very deed, confers an honour upon itself!

Those of us who were prepared by this great leader to serve others, were, indeed, privileged. Her spirit will live on in the School which, for so many years, *was* "Miss Hersey".

—ELSIE ALLDER

An Adventure in Human Experience

BARBARA CONVERY

There are many problems and skills involved in the nursing of pulmonary tuberculosis, and no attempt is made here to deal with them all, but merely to highlight a few that are sometimes forgotten, or at least may come to be regarded as secondary.

For the most part, these patients do not appear to be very ill, and do not require much physical nursing care. For this reason, to the unimaginative and undiscerning nurse, the daily care of her patients can become deadly, uninteresting routine. Yet, since tuberculosis is a chronic disease, the opportunity of knowing her patients is excellent and, if one regards the work from the psychological aspect, the field for skilled nursing and opportunities for dealing with human beings are unlimited.

On admission, the patient is usually in a state of mental turmoil. This is to be expected. Plans have collapsed, there are worries about family or financial

matters and, above all, he is probably terribly frightened about his own condition because, to the uninformed, tuberculosis is a strange and terrifying thing. It is an old and well-known cliché that contentment of mind is half the battle in any illness, and in none is this more true than in tuberculosis. It would be reasonable to say then, that treatment begins with reassurance. Although the active measures are usually undertaken by public health nurses, the ward nurse should know about the various organizations that aid in adjusting family and financial difficulties, in order that she may allay such worries. Without being too specific about time, she should suggest that tuberculosis is not really so dreadful as the patient suspects, and that the percentage of cures is high. It is of primary importance that your patient should believe in his ability to overcome the disease. Most people respond to a challenge, and you can inspire a spirit of fight in him.

After a short preliminary adjustment to sanatorium routine, you should persuade the patient, in a subtle way, to face the fact squarely that, on the one hand, he has an unseen but ever-present enemy to fight and, on the other, has a set of weapons. Rest, fresh air, diet, a happy mind, if used faithfully and well, can be completely effective. Then you will set about showing him how to use those weapons, and constantly but not too obviously encourage him to employ them — you will notice that we said encourage, not drive.

Because he fears the unknown, it is well to include something of the anatomy of the chest and the nature of the disease in your teaching programme. Of all his weapons, first and foremost is rest — and rest means just that. Teach your patient to lie down, or at least to lean back, to do almost everything. Remind him to use a minimum of motions for occupational or normal living activities. Teach him to keep his arms down and not to stretch. Make sure that rest hours are devoted to lying quietly and sleeping if possible. If the disease is unilateral, encourage the patient to lie on the affected side, thus reducing the possibility of infecting the other side by direct drain-over of sputum through the bronchi.

You must realize that there is always a temptation for the patient to do things and get things for himself. He doesn't feel ill, and that feeling of dependence on others is so distasteful that rather than ask he will "do it or get it himself". Hence you must anticipate his needs and wishes, and be cheerfully willing to do things for him. It is so important to create the realization that you are allied with him against a common enemy. Occupational therapy might be mentioned here, because it is directly connected with rest. It is of the utmost importance because it fills the need that everyone experiences to do something creative and makes a major contribution to a happy mind. However the patient should be taught to regard occupational therapy as one more tool for the reconstruction of sound health, and not as a series of projects to be undertaken and completed regularly.

In addition to rest there is fresh air — which needs little mention here because it is usually adequately provided for and the nurse need only see that the patient is kept warm enough and is protected from draughts. Diets should be attractively served and the patient encouraged to eat full meals. Snacks between meals are unnecessary and may actually prove detrimental. A slow steady weight gain is desirable. Finally, the importance of isolation technique must be thoroughly taught and continually impressed. Explain the methods of preventing the spread of infection and point out the danger of re-infection. This latter point is actually sometimes missed by nurses, and consequently by patients.

The summation of the guidance you will offer in your care of the tuberculosis patient then is this: help him to a happy, unconfused mind, with a clear picture of what he must do, and how he may do it. Make him see that his illness is not merely an interlude to be endured, but a time wherein he may learn many things, acquire new experiences, and prepare himself for the future in which changes may perhaps have to be made.

You, as a nurse, are in constant daily contact with the patient and are in a better position than anyone else to offer this guidance. It's an adventure in human experience!

War Comes to Labrador

HELEN R. HOSMER, M.D.

It had been a beautiful summer day, hot as weather goes on the Labrador coast, and with no more than St. M's average quota of biting flies. The shadows across the smooth harbour water were growing long as we finished stowing away the last of the hay. Our anticipation of a restful evening was not too much disturbed even by the purr of a motor boat's engine. Perhaps we were going to have company, too! So we closed the hay barn and joined the usual group hastening to the wharf.

But the trend of our thoughts was rudely changed by the words and expression of the boat's captain, Commander A. of the near-by construction camp: "We have some badly burned men here from a torpedoed vessel and there are three hundred more out there floating around in boats. I must get right back. Careful! Don't touch these men's arms!" And he brought ashore two men in whose blackened faces the eyes shone white, and on whom only charred pieces of shirts remained above the waist.

We did not stop that night to hear the story. There was too much else to do in removing the worst of the dirt from their arms and faces, in applying the protective dye to blistered areas, and in carrying out the necessary measures to give them rest and some degree of comfort. One man, the radio operator, had no intact skin up to well above his elbows, and very little on his face. But his plight was better than that of his comrade, a big muscular chap, who had slid down a rope to the life boat with his blistered hands, removing so deep a layer that the nerve ends were exposed. Even morphia only lessened his suffering and we had to use an anaesthetic the next morning to complete his dressings. These two men had been talking on a lower deck just above where the torpedo had exploded, and they had no memory of how they had gotten out.

They were such good sports, these men of the American Merchant Marine. Their chief complaint was their absolute helplessness. "Might as well be a baby!" as one disgustedly exclaimed when his cigarette had to be put into his mouth for him.

The next day brought us seven more survivors with lesser injuries, such as broken ribs and sprained joints. Late in the afternoon a captain of a smaller ship brought in his cook whose feet had been scalded by steam. The Captain also had severely burned ankles which he had got when trying to go below for a man with broken legs who was calling up a ventilator for help. "It is hard to leave a man like that," he said. He would only stay for a single dressing of his legs. He must go on to get food for his men. The one hundred and fifty people landed

in one small isolated settlement had almost stripped the place of provisions. And he must go back for another ship. "We never wanted this war", he said, "but we must go on with it!"

One of our most depressed patients said, "The officers on that ship were certainly heroes". He told of hearing one officer, with his legs broken, refusing help and directing the rescue of other men who had been shocked into immobility. Later he was seen leaning against the rail as the ship went down.

With one ward filled with women, we had to put beds in the hall and operating room. Fortunately one very slightly injured man had been a hospital orderly, and he took some of the night duty. Our chief concern was for the burn cases, and so we appealed to Commander A. to get a plane to take them to the base. This he did immediately.

The following day the minor injuries were picked up by a rescue ship. Here the resources of the clothing store served the United Nations, for we had to contribute the clothes to cover our patients whose expensive kits had gone to the bottom. As one explained, the weather had been so calm at the time of the torpedoing that the men were in shirt sleeves. But almost at once the sea began to rise with a strong wind so that it was very difficult to control the overcrowded boats and to row them the long six miles to shore. Three boats brought in over one hundred and fifty men, all standing in a foot or more of water for the seven hours it took to reach the land,

Only ten days later, while I was struggling with one of those firmly rooted teeth so characteristic of the coast, our nurse, Miss Jupp, who was acting as head rest, saw far out on the horizon a burst of flame followed by a cloud of smoke. "There goes another one" was our immediate thought, and we cleared the hospital wards for action at once. Sure enough, four hours later a motor boat appeared bringing, in the care of the Ranger's wife who is a nurse, "four of the biggest bricks", as she said, that she had ever cared for. They were Canadians, two members of the R.C.A.F. and two passengers, executives of a construction force on a northern base. Their plane had blown up while taxiing about waiting for a motor boat to come out to them. They had all been blown into the water, one being driven through the front of the cockpit. After climbing out onto a wing, they had been taken off by a rescuing motor boat just before the explosion of the gasoline tanks had lifted the rest of the plane a hundred feet into the air. They reached us still in their wet clothes, and the worst injured of them so covered with blood that for a time we feared a punctured lung. They were hurried into warm beds and given hot drinks at once. Countless cuts and abrasions were revealed, but some more serious injuries. Their only complaint was bitter regret at failing to save their pilot, to whom they were devoted.

For all of these men the discovery of a hospital in this remote region was a most grateful surprise, and they were unsparing in their appreciation, both at the time and afterward. I speak for the whole staff in saying that nothing could have given us greater satisfaction than doing everything in our power for such patients. The contacts with the victims of these two disasters were certainly confidence-inspiring for the future of our continent.

Editor's Note: This article is reprinted from "Among the Deep Sea Fishers", the official publication of the International Grenfell Association. Canadian nurses are already serving in the Grenfell Stations established at various points in Labrador but more are needed. Full information can be obtained from Miss Ethel Graham, secretary of the Grenfell Labrador Medical Mission, 48 Sparks St., Ottawa.

State Medicine versus Health Insurance

Everyone who is interested in health insurance should read Dr. Charlotte Whitton's stimulating treatise, published under the beguiling title of "The Dawn of Ampler Life". Dr. Whitton disagrees with most of the proposals embodied in the Marsh and Heagerty reports and, in so doing, helps to clarify some rather confused issues simply by challenging them. Her main contention is that Dr. Marsh relies too much upon the recommendations of the Beveridge Report which, in her opinion, were framed for use in a social environment very different to that of Canada. Dr. Whitton does not think that the establishment and assurance of a basic income, in terms of currency values, is either a sound or a feasible idea. Instead, she suggests that certain social utilities, including complete medical and nursing care, should be provided for all and sundry on a non-contributory basis.

The Heagerty plan for health insurance is challenged on several counts, especially in relation to the startlingly low estimate of what should be paid for hospital and nursing services as compared with the amount allocated for medical fees. Dr. Whitton believes that the proposed contributions will not nearly cover the cost of hospitalization and that it will therefore be necessary for the individual to meet the difference out of his own pocket. The only alternative would be to assess all contributors on a much higher scale.

Although Dr. Whitton offers an alternative to the Marsh and Heagerty plans it cannot be said to be crystal clear. The thinking seems a bit woolly in spots and the wording is correspondingly obscure. Nevertheless, her ideas about the organization of health services as a social utility are well worth studying. Briefly stated, they are as follows:

1. These services should not be financed on a contributory insurance basis.
2. The cost should be met by general taxation, specifically assigned for the purpose, along the general lines on which education is now financed in the respective provinces.
3. An adequate minimum standard of the services to be provided for all persons should be set up; the costs over and above this level should be met by the individual concerned.
4. Physicians and nurses should be employed full time and on a salary basis.
5. The direction of public health activities, including health education, should be undertaken by provincial and municipal public health departments.
6. In urban centres, there should be a close integration of hospitals, clinics, and visiting nurse services.
7. Health stations, including hospital accommodation, should be set up in rural areas. Dr. Whitton points out that existing military medical units could readily be converted for this purpose as soon as the war is over.

Dr. Whitton asks whether all this adds up to State Medicine and answers her own question in these words:

Is this State or Socialized Medicine? It is to the degree that specific services and staff are retained and made available like the schools, to all who care to utilize the public service of the area of their residence and taxation. As such it is an extension, not an innovation, in Canada, for in every province today, there are already considerable developments in State health care whereby medical, nursing, hospital and institutional care under full-time staff are provided entirely from the public funds of the province or municipality, or by private agencies aided by public funds.

It is recognized that this proposal removes the desirable direct contribution of the beneficiary for the services which he may receive. The value of the sense of participation and provision, inherent in the direct contribution, is an element worth preserving in a free society, where enterprise and responsibility are of its very amalgam. On the other hand, it is generally accepted in Canada that the Health

and Medical Services must be extended on the level of local and provincial administration, whereas the present taxing powers of these authorities are inadequate for their financing. Thus, in any case, the public contribution to these services will have to come in some part from another unit of government than that actually providing the service: and some device will be necessary in any event, to establish the relationship between the service provided and its cost.

This pamphlet contains some thoroughly constructive thinking on problems other than those directly related to health. Although the going may be tough, it is worthwhile to try to get the gist of it. This is the sort of background nurses need if they are to understand and cope with the social forces that are shaping a strange new world.

—E. J.

A History of the "R.V.H"

On January 2, 1894, the first patient was admitted to the Royal Victoria Hospital in Montreal and, a few days later, on January 10 to be exact, the first probationer, Agnes Taylor, entered the Training School for Nurses, organized by Edith Draper, the newly appointed superintendent of nurses. Accordingly, the fiftieth anniversary of this famous School is being celebrated this year and the auspicious occasion is marked by the publication of a history, written by Marjorie Dobie Munroe, who is herself a graduate of the School, and a member of the Class of 1925. Attractively bound in the School colours of purple and gold, the volume is dedicated to Mabel Frances Hersey who, in 1932, asked the author to begin to assemble material for it. Mrs. Munroe has done a beautiful piece of work and the School now has a complete and authoritative record of its early origin as well as of its development over a period of half a century.

The book is divided into three major parts. The first deals with the history of the Hospital, the second with the Training School, and the third with the Alumnae Association. A vivid picture is given of the careers of the Founders, Lord Strathcona and Lord Mount Stephen, "whose achievement is the story of Victorian expansion in Canada". Equally interesting thumb-nail sketches of other dynamic personalities add colour to the later years. Reference is made to Dr. John MacRae, the author of "In Flanders Fields" who, at the time of his death on active service overseas, was assistant physician and assistant pathologist at the R. V. H. A reproduction of the original manuscript of the poem is one of many striking illustrations.

The portion of the book which deals with the early days of the School will be eagerly read by all nurses, young and old. These pages are enlivened by pencil sketches, drawn by the author herself, which will surely awaken many memories. The Spartan midnight meal that each night nurse carried in a little basket to her ward, the late leave once a month, the twelve-hour night duty, are all described with delightful humour. Perhaps those *were* the good old days after all!

The sincere and moving tribute to the life and work of Miss Hersey is one of the best passages in the whole book. Mrs. Munroe has captured those elusive qualities of heart and spirit which made Miss Hersey what she was. She lives again in the dignity and restraint of the

lines which tell the story of a professional achievement which, in some respects, is unique in Canada.

Mrs. Munroe has not only rendered a great service to her own School — she has also written a glorious page in the history of nursing in Canada.

Editor's Note: The Training School for Nurses, Royal Victoria Hospital, by Marjorie Dobie Munroe may be obtained from the Training School office. Price $2.

Miss Effie Taylor Retires

The retirement of Miss Effie Taylor, dean of the Yale School of Nursing, has been announced by the President of the University. In paying tribute to Miss Taylor, President Seymour said: "Dean Taylor's retirement at the end of the college year brings to all members of the university a sense of deep regret and warm gratitude for her distinguished service. Under her administration, the School of Nursing has worthily maintained the ideals which characterized its original purpose and has constantly enhanced the prestige of Yale in this vital field of education".

Miss Taylor was born in Hamilton, Ontario, and received her early education in Canada. She is a graduate of the Johns Hopkins School of Nursing and for several years was director of nursing in the Phipps Psychiatric Clinic. During the first Great War she directed the Army School of Nursing at Camp Meade and later was appointed superintendent of nurses at the New Haven Hospital. In 1926 Miss Taylor received an honourary degree from Yale University and was appointed professor of psychiatric nursing, the first appointment of its kind ever to be made. In 1934 she succeeded Miss Goodrich as Dean of the Yale School of Nursing and has rendered such outstanding service that the School attracts admiring visitors from all parts of the world.

For five years Miss Taylor was president of the National League of Nursing Education and, in 1937, became the president of the International Council of Nurses, an office which she continues to hold with great distinction. Now that she is relatively free from other heavy responsibilities, Miss Taylor will be more in demand than ever by the nursing groups which make up the Council. She has already visited Canada in her presi-

EFFIE J. TAYLOR

dential capacity and we look forward to seeing and hearing her again. After all, she belongs to us by right of birth and we are justly proud of her.

A Greeting from the National Council of Nurses of Great Britain

Members of the Canadian Nurses Association will be happy to share the following message of greetings sent to their President, Miss Marion Lindeburgh, by Mrs. Bedford Fenwick, President of the National Council of Nurses of Great Britain:

Dear Miss Lindeburgh:

Just a few words from the heart of your colleagues grouped in the National Council of Nurses of Great Britain to wish you and the members of the Canadian Nurses Association as happy a Christmas as may be, and a victorious New Year.

In Great Britain, as you know, we are still heart and soul in this vital struggle with evil, and welcome all the help available from the valiant Dominions overseas.

With this little letter, I am forwarding to you for the Library of the Canadian Nurses Association, a copy of "The White Cliffs" by Alice Duer Miller, delightfully illustrated by Hilda Austin and Leonard Cotterill — a poem of great emotional power which is in tune with the times — hoping it will arouse loving thoughts of England, that glorious speck of earth in the North Sea!

I remain,

dear President of Canadian Nurses,
your colleague,

ETHEL GORDON FENWICK,
President, The National Council of Nurses of Great Britain.

This inspiring message and the very attractive copy of "The White Cliffs", by Alice Duer Miller, so appropriately illustrated, are tokens of goodwill and international fellowship which are particularly significant during the present days of stress, when Canadian nurses share with special professional pride the challenges being met with such determination and fortitude by nurses in Great Britain and other lands. The unique little volume will be added to other enduring evidence of Mrs. Bedford Fenwick's kind thoughts, which are treasured in the National Office of the Canadian Nurses Association.

Members of the Canadian Nurses Association join with Miss Lindeburgh in expressing cordial appreciation to Mrs. Bedford Fenwick, and in extending to her and to members of the National Council of Nurses of Great Britain all good wishes and assurance of loyal support as they face present difficulties so courageously and look forward to the brighter days that lie ahead.

Voyage of the "S. S. Gripsholm"

Not so many weeks ago, the Swedish steamer "Gripsholm" arrived safely in an American port. The ship was crowded with hundreds of men, women and children repatriated from the Orient, Among them were missionaries, teachers and nurses, many of whom had endured inconceivable hardship with courage and dignity. Although they had lost almost every personal possession, they at least shared the satisfaction of knowing that they had rendered magnificent service under conditions that were always difficult and sometimes extremely dangerous.

Ten Canadian nurses were members of that gallant ship's company and, when the time is ripe, we hope that they will tell us the story of their great adventure. In the meantime, their welfare is of great concern to all Canadian nurses and, under the caption of *Notes from the National Office*, it is made clear that the Canadian Nurses Association is prepared to render any service that will be of practical and immediate benefit.

Bacterial Infections of the Urinary Tract

MARY STEWART

The term bacterial infection is used when it is found that a disease is due to bacteria and their presence is established by isolation of the responsible organism. Infections of the kidney may be caused by bacillus coli, staphylococcus, streptococcus, tubercle bacillus and many other organisms; more than half are caused by bacillus coli. Pathological changes in the kidney vary with the infecting organism and its route of invasion. Bacillus coli involves the renal pelvis and is the organism usually found in pyelitis. Hemolytic streptococci cause glomerulo nephritis. The patient usually complains of frequent or painful micturition, chills, headache, and general malaise; there is usually an elevation of temperature.

In order to establish a diagnosis of renal infection, a careful history should be taken and a complete physical examination should be made. All tests should be carried out intelligently and proper preparation should be made for x-ray and cystoscopic examination. Urinalysis, blood count, and other kidney function tests may also be ordered and the non-protein nitrogen content of the blood should be ascertained. Urinalysis will show whether blood, pus, or casts are present. Blood counts will show whether the white blood cells or the polymorphonuclear cells are increased, thus indicating the degree of resistance to infection. In the light of these findings, the urologist will decide whether or not a cystoscopic examination is to be done.

Hydronephrosis, caused from an obstruction such as a calculus, can be visualized in the x-ray plates. Pyelonephritis may be either acute or chronic and is more common in women than in men. In women it has many causes but may occur as an acute disease in childhood or during pregnancy. In men it may be associated with acute retention of urine due to prostatic hypertrophy.

The nature of the symptoms of abscess of the kidney depends on whether the abscess is large or small, and whether there are other constitutional conditions such as a general septicemia. A rise in temperature, pain, chills, painful micturition, and tenderness on the affected side will usually be present. The white blood count will usually disclose a high degree of leucocytosis. The urinalysis will show the presence of albumin, bacteria, and varying amounts of pus. As the disease progresses, kidney function is diminished, uremia may develop and death result. Sometimes the disease becomes chronic and, if this is the case, a gradual rise in the non-protein nitrogenous content of the blood will result and the patient may develop a tolerance of the infection. Thus, a patient may have a non-protein nitrogen of 90 mgm., and not be critically ill.

The patient should be kept in bed in a bright, well-ventilated room, free from draughts. His clothing should be light and warm. Daily baths should be given. He should be encouraged to take as much fluid as he desires up to about 3000 ccs. in 24 hours. If he is unable to take this amount by mouth, the balance should be made up by intravenous method. A soft or light diet may be given. The fluid intake and output should be carefully checked and recorded. Good general nursing care is an essential.

Sulphathiazole in small doses is sometimes used and is found very satisfactory. The concentration of the drug in the urine is much higher than in the blood, hence the smaller doses ordered. Fluids are given in generous amounts. A complete blood count should be taken

before the drug is administered and white and differential counts should be made in four days and repeated in a week. Should the white or polymorphonuclear cells fall below normal, or a rash appear, the drug should be discontinued. Neoarsphenamine, in small doses, is administered intravenously with success in streptococci or staphylcocci infections. These drugs must be given under the supervision of the physician in charge of the case and any unusual reaction or change in the patient's condition should be reported to him at once.

Mandelix acid is effective in infections due to bacillus coli or staphylococcus. If the drug is to be effective it must be present in a concentration of 0.5 to 1 per cent and the urine must be strongly acid; pH (the symbol for acid concentration) must be maintained at 5.5 if the treatment is to be successful. Fluids are restricted. The treatments should not be continued longer than a week or two and the appearance of albumin or blood in the urine is an indication for discontinuing them.

The kidney is frequently the site of a tuberculous infection and, as the disease progresses, the bladder becomes involved. It may occur in persons who have never had any pulmonary involvement, but is always a secondary infection. It is usually unilateral but may become bilateral. The symptoms include polyuria, haematuria, pyuria, and dysuria. The disease is usually fairly well advanced before these symptoms appear. Constitutional symptoms are usually absent but as the disease advances there may be pain in the loin on the affected side. Cystitis may become troublesome and usually causes the patient to seek medical advice. Diagnosis may be made by means of a culture from the urine or by guinea pig inoculation. Catheter specimens may be obtained from each kidney in order to demonstrate whether unilateral or bilateral infection is present.

The patient may be advised that a nephrectomy is the treatment of choice providing that the disease is not bilateral. All urinary discharges from these patients must be carefully handled as they are usually loaded with tubercle bacilli. Following a nephrectomy, many of these patients make a good recovery but in a certain number of cases healing is delayed or chronic sinus forms. This is unfortunate but is due to the patient's lowered resistance which is the cause of inability to heal by first intention.

After they leave the hospital, these patients should continue to be kept under close observation so that any new lesion may be detected in its early incipiency. They should be taught to appreciate the importance of personal hygiene and its value in daily living. They should be encouraged to eat plenty of good food and to get sufficient rest — in short, to seek good living conditions. They will thus be able to return to their normal occupations in a relatively short time but should have regular medical examination after they begin working. Nothing should be allowed to interfere with this duty to themselves and to their friends.

The Journal is Late!

Yes, we know the *Journal* is late. Even if we were not painfully aware of it ourselves, the stern admonitions of advertisers and subscribers would bring the dismal fact home to us. The hackneyed excuse of "it can't be helped in wartime" is all we have to offer. But we would like to say that we are trying hard to cope with the difficulties that now beset every publication in Canada. Honestly, we are doing our level best.

Dame Katharine Inspects the Q. A. I. M. N. S.

On August 1st, I left England by air to make a tour of inspection in North Africa. I was going to see the nursing profession on active service with the Army. I travelled hundreds of miles and visited 14 large hospitals and I saw for myself Q.A.'s (our short nickname) living and working under conditions of total warfare.

It *is* grim. But they are busy and nothing matters when they have their nursing work to do. They have plenty of that — sick and wounded — friend and foe — and friend includes ally. What do they do? Well, they administer and keep discipline in the wards, nurse all the worst cases themselves, and supervise the nursing work of the R.A.M.C. orderlies, who are helping them splendidly.

After a long drive through vineyards and fig-groves and olive trees, we arrived at a railway crossing and saw beyond it rows and rows of tents and a few Nissen huts. The Nissen huts housed the cookhouse, the offices, the operating theatres, and x-ray room (all wonderfully equipped), and the acute medical and surgical wards. In the tents there were literally hundreds of beds, many of them occupied by patients suffering from malaria — often up-patients, but kept in hospital to get the modern treatment for this disease, which has been so successful that most of the men are able to leave hospital after 15 days. I saw infectious cases — sixteen German prisoners with diphtheria and even two of our own men suffering from smallpox, which is very rare. They were in small tents and nursed by volunteers, a young Sister (a general and fever-trained nurse) and nursing orderlies.

Then I was taken to the Sisters' quarters, a collection of lean-to tents, with two Sisters sleeping in each tent, and the whole surrounded by barbed wire to keep out any light-fingered local visitors. Sanitation is primitive, water is very scarce. Laundry is impossible and necessities are hard to get — all the stockings get lost en route. One American chief nurse I met was wearing a pair of man's shoes. The town is miles away and nothing can be bought in local shops anyway, because all clothing is couponed. But who cares? Not the Q.A.'s, nor the American or Canadian nurses. They're busy nursing all the hundreds of patients lying in the tents and huts just across the path.

Amongst the individual Q.A.'s who asked to see me all but one wanted to serve on a hospital ship, or in a casualty clearing station or a forward hospital, or even to volunteer as parachutists! I've got several names of Sisters who want to drop from the skies with the R.A.M.C.

I wonder if you read about the torpedoing of Q.A.'s on their way to North Africa — 212 of them. The very next day 207 started to nurse (I am sorry to say five were lost). They were fitted out in soldiers' clothes — it's all there was — underclothing, battledress fore-and-afts and boots. But they don't appear to have nursed any the worse for that, and indeed, it has proved to us that this clothing was the most suitable for the dreadful rain and cold in that part of the world in December and January.

The Principal Matron told me "there was no sign of any panic". And one matron, who was up to her armpits in water in a waterlogged lifeboat for six and a half hours, only remarked: "Yes, it was terrible, because we thought the boat might sink at any moment, but it didn't do me any harm at all — none at all". They were black with oil in one boat, and just before they landed, the Principal Matron produced a comb from her pocket and, handing it round, she said "Here, tidy up a bit, and try not to *look* like survivors."

They have lived in luxury hotels, villas, Nissen huts, tents, houseboats, dugout sunken quarters in the Western desert, native built mud huts in the Sudan, and on trek they have even slept in the open — for on one occasion nine Sisters were attached to a unit which followed close behind our victorious Army from Egypt to Tripoli — the first British women to arrive with the Eighth Army in Tripoli. They travelled in lorries and wore battledress, and a high tribute has been paid them for their nursing work with this unit.

Fifty Q.A.'s were in Greece, and did trojan work there, and again almost by a miracle they all escaped injury from the incessant bombing on their way from Greece to Crete and on to the Middle East where they arrived, sorry but safe. And so the story goes on, more and more, till now over 7,000 of these State Registered Nurses are serving with the Army everywhere, in hospitals, casualty clearing stations, hospital ships, hospital carriers, ambulance trains and camp reception stations.

They served in France — 13,000 of them — and all got back to England safely except one, who was badly wounded when a hospital ship was sunk in the Channel. Hundreds have been drafted overseas, to join the regular service in military hospitals in Egypt, the Sudan, Malta, Gibraltar, Hong Kong, of course, and Singapore. Fourteen of them are prisoners in Hong Kong and 44 others are still missing in Malaya.

Before I finish my story of the war areas overseas, I think I must tell you a little about the Sisters in India, the Middle East and Palestine, and East and West Africa, too. There they're nursing patients in combined hospitals; that is, for both British and native troops. You see, nursing is international, and our patients are of every creed, race and language. I hear of Sisters learning Hindustani, Arabic and Swahili — sometimes they even start on the ship on the way out — and I hear about the many wards full of native troops from all corners of our Empire — yes, and sometimes full of women and children—civilians, evacuees, our own and Allies — all patients of ours wherever they are to be found in beds in our hospitals. You see, when there is a special state of emergency, as in Singapore, and on ships, we nurse everybody and anybody who needs nursing.

But if you were to ask me what was the main impression I brought back with me to my office stool at the War Office —from my tour in North Africa — I think I should say it was the feeling I got, that there is complete co-operation between the R.A.M.C. officers and personnel and their sister service, the Q.A.'s, and that this results in the very best medical and nursing care being given to our soldiers, wherever it is our privilege to nurse them.

Editor's Note: This article is the substance of a broadcast given by Dame Katharine Jones, D.B.E., R.R.C., Matron-in-Chief, Q.A.I.M.N.S. The original article appeared in The British Journal of Nursing, October, 1943.

The W.P.T.B. Cracks Down

Under the regulations of the Wartime Prices and Trade Board only subscribers in good standing can be retained on the *Journal* mailing list. We can't wait around as we used to do in the hope that, when she gets round to it, the lady who is in arrears will do her duty by us. When the renewal slip arrives it means business. Two dollars, please.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association.

The Principles Involved in Staff Education

HELEN G. MCARTHUR

What is staff education? Virginia A. Jones, assistant director, National Organization for Public Health Nursing, interprets it, in the broadest sense, to mean any efforts made by an agency to further the development of its staff members. Then, why have administrators and supervisors of public health nursing agencies rather suddenly become "staff education conscious"? Staff education itself is as old as the earliest visiting nurse associations, for staff meetings and supervisors' conferences have always been used for educational purposes. Are we, as public health nurses, just taking up another fad, or are we realizing what a sorry job we have been making of it and admitting our attempts have failed miserably to do the job they were intended to do? If we are accepting staff education as a means and not an end in itself, then it is worthwhile for nurses to study and talk about it, but if we are going to be very busy starting staff education programmes, whether we know how to go about them or not, because "all the best agencies are doing it", it would be much better to leave our public health nurses alone, busy at their work.

Let us go ahead on the assumption that we want to do a sound job of making staff education a supervisory tool that can be used. The agency accepts the responsibility for the initiation of the programme because it receives returns in better service. But the agency's responsibility is not so much keeping the nurse up-to-date as keeping the job up-to-date. It is time to control the urge, on the part of administrators and supervisors, "to stimulate the nurse". The necessity to stimulate the nurse's interest is open to question, for are not trained public health nurses famous for their ability to meet the challenge of vital, expanding pieces of work under all types of working conditions? When the job is worthwhile, in an ever-expanding field of endeavour, the nurse is the first to cry out her need for guidance. It is the responsibility of the agency to meet that exigency with a programme of staff education that fulfills its purposes when constructed to meet these everyday needs of the public health nurses.

To make a programme of staff education function requires study, sound planning and hard work, especially by the leaders. The programme is most effective when there is group planning and participation. It is necessary for administrators, supervisors, and staff nurses, working together, first to learn how to go about developing a plan. Simply finding the answers to such questions as:

"Why are we meeting?", "What do we want to accomplish?", and "What are the most effective methods?" will help them become more effective in their efforts at in-service growth. Given democratic leadership and a demonstration of order in thinking and action by the leader or supervisor, the nurses cannot help but respond. When orders and commands become instructions and leading, through co-operative processes of group action, and the autocratic methods of power and fear are displaced, results become apparent. When the programme is organized and executed on the basis of the individual differences in nurses, not merely for the sake of imparting knowledge, but to help the nurse develop attitudes that will bring productive results in her work, then the programme becomes of vital importance to each nurse.

As to method, it must be admitted that the lecture method has held the floor too long. Discussion methods are now accepted intellectually by our leaders, and now is the time to try them by learning how to use them, and then putting our knowledge into action. The first step in any staff education programme is to brush up on the elementary rules of parliamentary procedures and to study the various forms of group discussion, such as lecture forum, symposium, panel, project method and many others, keeping in mind the problem-solving technique rather than the subject matter approach. Each group should learn the responsibilities of the leader and even more important, the responsibilities of the individual members of the group. The individual conference can be kept in mind for problems not suitable for discussion by the whole staff and is effective when it provides guidance, allows for privacy and for discussion of personal problems.

After a sincere attempt to find out how to carry on staff education programmes and translating that knowledge into action, it is necessary continually to evaluate the results by careful analysis of what is being done in order to see if it is working. If not, then the plan is discarded for another method, or the way it is being done is improved, never satisfied with partial success, but ever striving for a more effective staff education programme.

Finally, when the programme is well on its way, if opportunity is provided for the nurse to apply her new-found knowledge, she will not forget it, but will be eager to go on developing herself and her work. If, however, after preparing herself to act, she is blocked in translating her new enthusiasm and information into action on her job, she is cheated and cannot be expected to respond to future attempts to lift her beyond her level of attainment, or she looks for another position. Either way, the agency does not receive the benefits of improved service, the original objective of the expenditure of time and effort by the staff.

It would seem then, that the main principles involved in staff education are: that public health nursing agencies provide incentive for study by presenting each and every staff nurse with work so challenging that there is continued expression of needs; that supervisors, as well as guiding nurses to see additional problems, must arm themselves with sound educational methods in order to initiate a programme of education to meet the individual needs of the staff nurses who differ in their problems and potentialities; and, through group planning and participation, help the staff nurse to accept the responsibility for an active and reasonable part in the programme. Each staff nurse must realize that unless she has the courage and develops the ability to express her problems the programme cannot fulfil its purpose. After working and studying together, the administrators, supervisors and staff nurses, by evaluation and

re-evaluation of their efforts, should be able to see the results of the continued growth of their staff education programme reflected in the realization that each of them is finding the way to a more satisfying professional life — and yes, a more satisfying personal life too, and then on to better service to their community.

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Social Service Aspects of Cancer Control

Margaret M. Dewey

In preparing this brief comment on the medical social follow-up of cancer, I have in mind not only the work done by the clinic follow-up nurse, but also the help that can be given by the visiting nurse. In our cancer control centre, the visiting nurse is in contact with every department of the centre and it is thus possible to co-ordinate all cancer control activities. By home visiting, she learns why the patient has not returned to the clinic or why she has not finished her series of treatments and acquaints herself with the unexpected conditions that sickness has caused in the home or at work. The district health nurse may do the same. This information is necessary for the patient's completed history and, more important still, it is a necessary step toward the removal of obstacles in the way of treatment.

Cancer control centres are working not only for the temporary or lasting benefits their efforts may bring to their patients, but also toward the compilation of statistics which are supplying the information necessary to change and regulate radium and x-ray therapy from time to time. For this reason, a very accurate account must be kept concerning every patient with a malignant disease. In order to simplify the tabulated records, the location of each lesion comes under its own classification. This may be mammary cancer, uterine cancer, oral cancer, cancer of the lip, cancer of the skin, or other types of cancer. Each of these classes is again subdivided and, after the doctor has made the diagnosis and outlined the lesion, it is treated with its own special therapy which may be given either for palliative or curative purposes. The result has a definite statistical value and must be recorded.

In the cancer clinic, hospital record keepers daily classify statistics so that the attending doctors may readily review the results of their work. Surveys are frequently made of cases carried over a certain period of time. When completed, they show the percentage of cases which are either symptom free, arrested, not benefitted, or dead. In order that these statistics shall be as complete and accurate as possible the record keepers, with the aid of the social follow-up

nurse, keep a constant check of all radiotherapy patients who have attended the clinic. This is considered an important part of hospital work, not only because of the benefits derived by the patient but also because statistical information is necessary to show the result of treatment.

The social service nurse cannot, unaided, do this follow-up home visiting. The district health nurse can and should do her part in visiting and reporting the progress made by patients in those districts not reached by the clinic follow-up nurse. The district nurse may be the first to detect symptoms of cancer in her contacts. She can then direct the suspect to obtain the early diagnosis which is so important a factor in successful treatment. She may ask: "How may I attempt to detect cancer in its initial stage, and what advice should I give to a potential victim?" Let me answer this question by giving a few simple illustrations of what, in her routine visits, may make her suspicious of danger. Mrs. A. looks healthy and is not complaining of indisposition but asks if it be right for her to have some bleeding between her periods. Or, after the menopause, Mrs. B. to her surprise, may have discovered that she begins to bleed again. While dressing or bathing, Mrs. C. discovers a small lump in her breast or an oozing from her nipple. Is that unusual? Shall she wait awhile, or does she need to worry about it? Mrs. D. has a small spot on her face that bleeds sometimes when the towel passes over it. It heals, then bleeds again. What should she put on it and what should she do about it? Mr. E. has a so-called cold sore on his lip. It has been there a month or more, why does it not disappear? Mr. F. has a pain in his stomach and thinks he has eaten food that upset his digestion. He has taken several laxatives but the pain persists. What might he try now? These are questions frequently heard by the clinic nurse and so are likely to be heard by the district nurse. She is also likely to hear of or see innocent-looking lumps or masses which are not causing any inconvenience, but she will advise that they be investigated for diagnosis. Any one of these complaints may be a symptom of an incipient cancer.

The nurse who is fortunate enough to get immediate action from these patients is affording untold benefit to the patient and to the community as well. It is her duty to advise the patient to see her doctor at once. He in turn, being suspicious of the dreaded disease, will send the patient to the nearest cancer control centre for a definite diagnosis and treatment. The health nurse should avail herself of every opportunity to encourage the people of her community to come to her for advice regarding persistent lesions or pain. She can be the intermediary between patient and doctor. By speaking at women's institutes and clubs, or at any local meetings, she can make her community conscious of the curability of incipient cancer and should never neglect any opportunity to emphasize the extreme importance of early treatment. In Ontario, the question of transportation for needy patients is no longer a problem. Through the local doctor, the unorganized districts may notify the Provincial Department of Hospitalization and secure travelling accommodation. The organized districts may make similar arrangements through municipal welfare departments.

After the patient is diagnosed, treated and discharged from hospital, the visiting health nurse can be of great assistance. On discharge, every patient is given written instructions as to how he can take care of himself with regard to dressings, drugs, diet and activity. The nurse visiting these patients can decide how well these instructions have been carried out and give her advice when they have not been successfully followed. Where nursing care is not adequate in the home, she can contact the

doctor or a relief organization, and application may be made for admission to the nearest local hospital, nursing home or hospital for incurables.

Do the results prove that it is worthwhile for a visiting nurse to encourage and help these suspected or diagnosed cancer cases? Let me quote a few statistics from the records of the Ontario Institute of Radiotherapy in Toronto. Long statistical tables are monotonous and are apt to be passed over so the following summary of results has therefore been reduced to its simplest terms, many minute details being lacking.

Extent of lesion: In order to estimate the extent of a malignant lesion, we speak of it as being in stage one, two, three or four. Stage one is the initial stage.

Cancer of the cervix: Three years after the completion of treatment, 82.1 per cent of stage one cases survived and, at the end of five years, 78 per cent survived. Among cases in stages two and three who had completed treatment, 18.2 per cent survived at the end of five years. In stage four, at the end of three years after the completion of treatment, 12.1 per cent survived and, at the end of five years, 2.8 per cent survived.

Post-operative cases of cancer of the breast, treated from 1937 *to* 1938: At the end of three years, 83.6 per cent of stage one cases survived and, at the end of five years, 74.6 per cent survived. Among the cases in stage two, at the end of three years, 61.4 per cent survived and, at the end of five years, 38.7 per cent survived.

Cases of cancer of the lip treated from 1934 *to* 1939: Among 340 stage one cases treated during this period 98.7 per cent were symptom free. Among 108 stage two cases, 87.4 per cent were symptom free.

Cases of cancer of the tongue treated from 1934 *to* 1939: Among the cases in stage one, 100 per cent were controlled; in stage two, 78 per cent controlled; in stage three, 54 per cent controlled; in stage four, 37 per cent controlled.

You will remember that these statistics are for the perusal of the nurses only. Doctors would demand a more careful study with minute details all of which could be obtained at the Institute. Recorded statistics of other malignant forms of the disease show corresponding results which are of sufficient value to encourage all nurses to look for and refer for advice any possible incipient case of cancer. In order that the clinic in any cancer control centre may give its best service to the community, the heartiest co-operation is necessary. Every department has its own function to perform and each is looking forward eagerly to the time when it can be said: cancer *is* controlled.

A Dad to his Daughter

Dear Daughter,

First of all, hearty congratulations on having served your term as nurse-in-training, and graduated with such high honours. As you are now stepping into the full vigour of maturity I am offering you a few thoughts which, in my humble opinion, are well worth pondering over and bearing in mind. While you read this letter erase from your mind any shortcomings, faults or frailties, which you may have seen in your Dad, and let your mind dwell on the ideal for which we are all striving.

History has taught us that each war is followed by suffering, and the greater the havoc, waste and destruction, the greater and more devastating will be the aftermath. Today's war, global in extent, and destructive far beyond the limits of human understanding, has already sown the seeds of pestilence, famine and death. The Four Horsemen of the Apocalypse sweep the earth, destroying or maiming and, the longer the duration of the war, the more furiously they will ride. Indeed, their horrid heads have already been raised in Bengal where 25,000 persons have

died from disease and famine in four months, and in Greece where over a thousand persons die each day from starvation. An ugly shadow of things to come: chaos, famine, plague and despair for unnumbered people.

Quite a task ahead of us? Yes, but not too heavy. There are always workers for the harvest fields, always someone to lend a hand if we plan and use discretion. There is more than despair in life, there is also joy and gladness. There is a glorious sunrise and a beautiful sunset every day, although sometimes clouds blur the vision. Anything written here is not based on any particular creed or dogma, but rather on the generally accepted belief in the immortality of the soul, the Fatherhood of God and the Brotherhood of Man, be he black or white, red or yellow, rich or poor, savage or civilized, saint or sinner.

First, guard well your health and reason, remembering that your physical body, that temple not built by man, is a dwelling for you, a wonderful gift from your Creator. Give unstintingly a goodly measure of your energy, talents and material resources, but let your giving be guided by prudence. In the flotsam and jetsam of humanity seek to see only with the eyes of your Creator. The fallen, weak and irresponsible we have always with us but let us be kind to them. Perhaps, most of all, their need is a word of encouragement, a smile or a handshake.

The waters of the Ottawa have tumbled and rolled over the rocks of the Chaudière for ages. But it is only in the last few decades that man's ingenuity and engineering skill have harnessed that great power. Within us are great spiritual values, tumbling and rolling, running away, awaiting our understanding to lay hold on them and tap their resources. The secrets of nature are revealed only to those who seek, faithfully, diligently and intelligently. Let your thought therefore be: "God in the midst of me is mighty to quicken, to strengthen, to heal, to vitalize, to renew and to make whole". In all things strive to see the great creative power of spirit, even in what we call the insignificant things of life. God is in the energy of the ant, in the swiftness of the dragonfly, in the daintiness and beauty of the butterfly. Take joy in the little things close about as well as in the larger things beyond man's comprehension.

Someone has written: "Out beyond the range of human vision is a vast world, dwelling place of a hundred million universes, where the stars wander in solitary confinement. Earth, sun, and moon are but grains of sand on its limitless shore. Infinitely small is yet another world in the realm of the electron, and between these two worlds stands man. Nature and the earth are willing — only man's imagination is lacking — to supply God's bounty to all mankind."

Miss Mary McCuaig Retires

After rendering outstanding service to the Victorian Order of Nurses for the past fifteen years Miss Mary McCuaig plans to retire from active nursing. Miss McCuaig is a graduate of the School of Nursing of the Toronto General Hospital and took postgraduate work in public health nursing at the Toronto University School of Nursing. As a member of the R.C.A.M.C. Nursing Service she served both in England and France during the first World War and was mentioned in dispatches for distinguished service.

In 1928 Miss McCuaig joined the staff of the Victorian Order of Nurses and, always ready to be placed where her services would be most effective, her first assignment was in Nova Scotia where she opened the Lunenburg Branch. Following this she was appointed in charge at Edmonton and later supervisor of the Western provinces. For the past eighteen months Miss McCuaig has been supervising in Central Ontario. Possessed of a genuine liking for people, and a sincere interest in their welfare, she won from professional and lay groups alike support and respect for the organization and personal affection. She will be missed by a host of friends from coast to coast and her resignation was received by the Executive Council with deep regret.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

A Central Registry Can Be a Teaching Centre

L. Evelyn Horton

Thanks to the formation of central registries for graduate nurses throughout Ontario, under the direction and with the assistance of Miss Madalene Baker, many of the smaller communities are receiving better nursing service and, through the efforts of central registries, the education of graduate nurses is being and can be continued. Certainly the nurses of St. Catharines and the surrounding districts have greatly benefitted through the help they have received from the nurses' community registry which has been functioning since January, 1943.

Due to the acute shortage of graduate nurses, many married and inactive nurses have been called upon to meet the emergency and the auxiliary list of the central registry was steadily growing thus enabling urgent calls to be filled which otherwise could not have been. With the return of these nurses to active duty came the request for a refresher course which would bring them up-to-date on the latest developments in scientific medicine and nursing methods. The educational committee of the central registry in St. Catharines took up the challenge and plans were made accordingly. The committee agreed that a concentrated course, carried out for a number of consecutive days, would not only stimulate interest but would also fulfil the purpose of the course.

It was necessary to obtain a room which would serve both for lectures and demonstration purposes, and would be large enough to accommodate the number of prospective registrants. We were fortunate in securing such a room in an up-town church which was both central and convenient. The course covered a period of four days and lectures were given daily from 9 to 11.30 in the morning and repeated each evening from 7 to 9.30 p.m. for nurses who were unable to attend the morning sessions. The availability of a qualified and experienced instructor in nursing who could give full time service simplified the planning of the course. (*Editor's Note*: The *author of this article was herself the instructor.*) A detailed outline was drawn up and mimeographed for distribution among the registrants. Copies were also sent to neighbouring hospitals which are served by the community registry, and the response was encouraging. Notices also appeared in the local press. A registration fee of $3 was charged in order to defray expenses.

Mimeographed outlines of all procedures were distributed each day as the procedures were covered. Because the nurses taking the course represented

many hospitals throughout Canada and the United States (as well as one registrant who came from the University School of Nursing in Holland) different methods were suggested and emphasis was placed on the general principles which do not vary much. The need of adaptability on the part of the nurse was stressed, not only to different hospitals, but also in relation to carrying out treatments in the home which involve the ability to improvise.

The eager response of the nurses did prove the need for such a course and on the opening day *seventy* were enrolled. The room was made attractive by hand-made posters, formerly used for teaching purposes by the instructor. Many of the drug companies willingly sent literature on new drugs for distribution. One of the publishing houses provided many new textbooks for display, and the book table proved an attractive rendez-vous for the enthusiastic group, many of whom expressed their wish to secure some of the books. It is hoped that a reference library may later be started for the registry.

On the opening day, all lectures were given by the instructor and dealt with health teaching in general, with special emphasis on the private duty nurse as a health teacher. The rest of the day was given over to a discussion of the newer drugs, vitamins, and glandular preparations. Special emphasis was placed on nursing care in connection with chemotherapy, especially the prevention and treatment of toxic manifestations. The preparation of solutions, fractional dosage Young's Rule for children, and Fried's Rule for infants were reviewed. Sample problems were worked out and the group were advised to review the principles of simple arithmetic, and the apothecaries' and metric tables. A review and demonstration of the preparation and administration of hypodermic injections stressed the dangers to be avoided.

The main topic for the second day was abdominal surgery and thyroidectomy. A prominent surgeon gave the initial lecture which was followed by a lecture from the instructor on the nursing aspects. Intravenous infusion was demonstrated and methods of indirect blood transfusion were correlated. The catheterization tray was reviewed and demonstrated. An explanation of the Wangensteen suction and its uses completed the programme for the second day. Mimeographed procedures were again distributed. The topic for the third day was obstetrics and an outstanding obstetrician treated the subject in an interesting manner. This was followed by a lecture given by the instructor on obstetrical nursing. Trays for perineal care were demonstrated and the methods used by different hospitals were explained.

The fourth day brought the grand finale and the enthusiasm created by the previous lectures proved the popularity of the course. The topics covered by the instructor on the fourth day were medical nursing, including the advances made in the treatment of pernicious anemia, diabetes, and pneumonia. These were presented from the nursing angle, with special emphasis on nursing problems and health teaching. Another topic was diagnostic tests and was chosen because the present-day nurse must be able to interpret laboratory reports, and should know what the normal findings should be so that she will realize the significance of deviation from the normal. As usual, mimeographed outlines were distributed. An hour was devoted to a round table discussion for which the topics were prepared and distributed beforehand. It was with fear and trembling that this extra hour was added to an already crowded programme but the eager response of the group soon dispelled all forebodings. The round table dealt with improvised equipment in the home, the value of charts, means of securing the comfort of the patient, and the essential

qualities for success in nursing.

It was with a feeling of regret and triumph that our first refereshcr course for graduate nurses in St. Catharines was brought to a close. Many registrants expressed the wish for the continuance of study groups which might meet monthly to further review other phases of nursing which could not be covered in the brief span of four days. These thoughts seem to be in the minds of all of us: "Learn to give to your work a little more than is required. Be expendable in service to others and forget yourself. Give to the world the best you have and the best will come back to you."

From the Patient's Point of View

ANNETTA LANDON

This article has been written primarily as a tribute to the bedside nurse — undergraduate as well as graduate. Not so long ago I found myself critically ill, among strangers and in a hospital other than my own. At first, this was a terrifying experience and it seems now, as it did then, that it could not be happening to me. My first recollections are of the people that I saw and relied upon most — my private duty nurses. Until that time my contact with private duty nurses had been purely personal, and I had not begun to appreciate just what it means "to be able to give expert nursing care in all types of illness".

In discussing the qualities and traits of a nurse that seem desirable from the patient's standpoint, I should say that the accent is first on the spirit — and then on the art and knowledge of nursing. Naturally, one would like to feel, and indeed expects, the nurse to be relatively skilful and to have acquired better than average knowledge of the science of nursing; but to have one who is sympathetic, understanding and considerate is highly desirable. The association with the nurse should give the patient confidence, and a feeling of security and strength. Then, too, one does not need to be ill to prefer the presence of a cheerful person — not too cheerful — but one who looks and acts as though she enjoyed doing what needs to be done.

The patient likes the nurse to be resourceful and to possess initiative and foresight. Just as a good operating room nurse is a lap ahead of the surgeon, so a good bedside nurse anticipates the wishes of the patient. For example, the nurse who warms the bed pan (and most nurses do) and foresees subsequent needs is the one you hope to see again. A patient readily perceives lack of interest on the part of the nurse and, as her illness is of paramount concern to her, soon resents the nurse who seems uninterested or detached, no matter how skilful she may be. A patient easily senses emotional concern, so emotional stability is a prerequisite. A calm, well poised nurse emanates confidence. It is also important, on occasion, that the nurse be firm though gentle in handling exacting patients.

Tolerance with regard to religious beliefs and practices is appreciated by the patient, particularly when seriously ill. The nurse who responds with consideration and thoughtfulness to the religious needs of the patient and who co-operates in fulfilling them, aids in establishing a sense of spiritual well being.

As the patient's progress is of primary concern to the immediate family they

are usually understanding and co-operative concerning visiting, and they in turn, should be treated with the consideration and thoughtfulness that they deserve. It is the strain imposed by entertaining the casual visitor that wearies the patient. One favourable outcome of the shortage of nursing staff, to my way of thinking, is restricted visiting hours.

In discussing personal appearance, I should say that one would prefer a nurse who is healthy, neat, well groomed and meticulous about her personal hygiene. With regard to uniforms, may I suggest that I found starched ones disturbing. In a home or a hospital, particularly at night, one finds floors, doors or furniture that creak. This probably cannot be remedied, but the crackle of highly starched uniforms bothers the patient much more. In a hospital, the rustle caused by several nurses in starched bibs and aprons passing along the corridor suggests a mild hurricane. Less starch, or none at all, would please the patient more, and from a practical point of view would lengthen the life of the uniform.

Patients have other preferences too, such as the nurse who treats their possessions as she would her own, as well as the one who tells them "what is going to happen next" providing, of course, that this is advisable. They like the nurse who has their comfort at heart and is attentive to small details such as the pleat in the covers at the foot of the bed which allows that very necessary toe room. (Fortunately, the present trend is to emphasize the comfort of the patient rather than the neatness of the finished product.) In most instances, the patient would also prefer being ministered to by one nurse, rather than by a series of nurses, but this, of course, is an administrative problem.

From the foregoing paragraphs the reader has probably gathered that, despite change and progress, the qualities and traits of a nurse that today are acceptable to the patient have remained the same throughout the years. The writer has found that a serious illness brings home most vividly the importance of these characteristics and that it may be a hard way of learning: "Do unto others as you would have them do unto you". I have been told that in some schools it is part of a nurse's experience to be confined to bed for one week. This would be a simple way of getting the feel of things from the patient's point of view.

M.L.I.C. Nursing Service

Marie E. Cantin (St. Vincent de Paul Hospital and University of Montreal public health nursing course) was recently appointed educational director for the Montreal nursing staffs. Miss Cantin was formerly head nurse on the Mount Royal nursing staff.

Lucille Cote (Providence Hospital, Montreal, and University of Montreal public health nursing course), of the Mount Royal nursing staff, has been loaned to the School of Public Health Nursing, University of Montreal, to act as assistant to the director, Miss Alice Girard.

Alice Albert (St. Vincent de Paul Hospital and University of Montreal public health nursing course) has been loaned to the Association of Registered Nurses of the Province of Quebec for a period of one year. Miss Albert was supervisor of the Frontenac nursing staff, Montreal.

Jeannette Coulombe (St. Sacrement Hospital) has been appointed to the Mount Royal staff.

Berthe Bourbonnais (Hotel Dieu St. Joseph and University of Montreal public health nursing course) has been transferred from the Quebec nursing staff to the Frontenac nursing staff, Montreal, to take charge during Miss Alice Albert's absence. Miss Bourbonnais was head nurse on the Quebec staff.

Contributed by the Hospital and School of Nursing Section of the C. N. A.

Refrigeration Anaesthesia

FLORENCE MCLEOD

It is not a new fact that extreme cold numbs exposed portions of the body. Any child who has made snow-balls with his bare hands is familiar with the sensation of numbness of the fingers which follows the initial feeling of cold and tingling but the application of this principle to anaesthesia in modern surgery is new. Ice anaesthesia, or refrigeration anaesthesia, is produced by the application of ice and is a chilling of a limb but not a freezing of it. The temperature is approximately 38° and is used in the amputation of the limbs of arteriosclerotic patients and in cases with gangrenous extremities where general anaesthesia is contra-indicated. A short synopsis follows of the methods used in one hospital for refrigeration anaesthesia.

A tourniquet must be used to aid in promoting anaesthesia by numbing the tissue so ice caps are applied to the limb for one half-hour, at the proposed level of the tourniquet, at the end of which time a tourniquet is applied. Immediately following the application of the tourniquet, the limb is placed on a rubber sheet on which is a thick layer of cracked ice. The entire limb is then covered with ice from one to two inches below the tourniquet to the toes. The head of the bed is raised eighteen inches; the rubber sheet is wrapped around the leg to hold the ice close to the limb and also to form a trough or funnel through which the ice water can run into a pail which has been placed at the foot of the bed. The ice is left on for two and a half hours following which time the patient is taken to the operating room in bed.

Sometimes, before the application of the tourniquet, an Esmarch bandage is applied from the distal tip of the extremity to the proposed level of the tourniquet and is removed as soon as the tourniquet has been applied. The use of the Esmarch bandage is contra-indicated if any infection is present. If the amputation is to be below the knee, and the patient is strong enough, he may be propped up in a chair and the leg immersed in a pail of ice and water. This method requires one and a half hours.

In the operating room a complete surgical staff is waiting for the patient. A nurse inserts absorbent cotton into the patient's ears to prevent the noise of the instruments from annoying him, especially the sounds from the saw. The patient is moved from the bed to the operating table, the ice is removed, and the leg dried quickly without rubbing. An antiseptic solution such as tincture of Metaphen or tincture of iodine is

then applied, the leg is draped, and the operation performed. Throughout the operation, chilled saline is used for moistening sponges.

Refrigeration anaesthesia lasts about one hour. The pulse, respirations and blood pressure are taken every five minutes during the operation and should show very little change. As soon as all the large blood vessels have been tied, the tourniquet is removed; the remaining bleeding vessels are tied and the retention sutures are inserted. When the operation is completed the stump is bandaged lightly but snugly and is placed on a moulded posterior plaster splint. The patient is placed in bed and taken to the ward and three ice caps are applied to the stump for from twenty-four to seventy-two hours. As ice retards the healing process, the ice caps are not left on longer than is necessary.

There is no post-operative shock following these amputations and, on return from the operating room, the condition of the patient may be better than before the operation. There is seldom any gastro-intestinal upset, thus very little modification of diet during the first twenty-four hours is necessary. The patient may require some sedation for the first seventy-two hours. Otherwise, the usual general nursing care is all that is indicated. The retention sutures are removed about the tenth day, at which time the stump is completely healed. The majority of these patients make an uneventful recovery.

Rural Internship for Student Nurses

An experiment in rural hospital experience for senior students, believed to be the first of its kind in the United States, has been completed by the School of Nursing of the University of Minnesota, according to a report received by Miss Lucile Petry, Director, Division of Nurse Education, U.S. Public Health Service.

Doctor W. C. Coffey, president of the University, reporting on the success of the experiment, points out that it was undertaken at this time primarily to prepare students to meet the nursing needs of the rural areas, where the shortages in hospital services are attributable in part to lack of understanding of the opportunities for service. The major purposes were: to acquaint the students with technique and equipment, and to familiarize them with some of the problems of smaller hospitals; to enable them to secure a more complete picture of patient care by seeing the background from which the patient comes and by learning of the contributions made by various groups in the community, along with their existing inter-relationships; and to provide, through the students themselves, assistance to the rural hospitals in their nursing service; and to insure more adequate rural medical care by attracting more nurses to work in rural hospitals upon graduation.

The trial period in this experiment was divided into two terms and provided experience for four different groups of senior students. The two rural Minnesota Hospitals co-operating were Itasca County at Grand Rapids, and Wesley Memorial at Wadena. Both are on the approved list of the American College of Surgeons.

All of the participants, the School of Nursing, the Nurse Co-ordinator, the senior students, and the rural hospitals, without a single dissenting voice, attest to the success of the experiment. As one of the hospital superintendents put it, the student is brought face to face with the fact that rural hospitals do some of the finest work in both medicine and surgery; that rural hospitals have the most modern equipment; that rural doctors are just as capable as the doctors in the city; and last but not least, that the people in the rural areas are just as wholesome, ambitious, friendly and educated as the average person in the city. It is expected that this successful experiment will result in its continuance at the University of Minnesota and in its widespread adoption in other parts of the country.

Notes from the National Office

Contributed by KATHLEEN W. ELLIS

General Secretary and National Adviser, The Canadian Nurses Association.

The Twenty-second General Meeting

Preparations are under way for the twenty-second general meeting of the Canadian Nurses Association, which is to be held in Winnipeg from June 26 to July 1, 1944, with headquarters at the Fort Garry Hotel.

As already announced, the general sessions will be held from June 27 to June 30 inclusive. These sessions will be devoted largely to business and discussion of vital problems that are of such special concern to the nursing profession at this time. Under the direction of Miss Marion Lindeburgh, President, and Chairman of the Programme Committee, plans are being made to ensure a presentation of reports and other matters of business that promises to be both vital and interesting. Special speakers will participate. Local arrangements are in the capable hands of Miss Ina Broadfoot, Winnipeg, who is chairman of the arrangements committee. Already plans are under way to ensure the success of the convention and the comfort and convenience of delegates. The educational exhibit is to be a feature of special value and interest. Provincial associations have been asked to support this project by making contributions.

In 1942 the celebrations of the tercentenary of the arrival of Mlle Jeanne Mance in Montreal made the general meeting of the C.N.A. one of particular significance. In 1944, the Sisters of Charity, Grey Nuns, will celebrate the hundredth anniversary of their arrival at St. Boniface, Manitoba. Happily the Canadian Nurses Association is holding its biennial meeting in Winnipeg this year. By so doing an opportunity will be afforded the association to recognize this great event, which is of both professional and historic interest.

Nurses across Canada are urged to attend the convention and to make use of this opportunity to participate in a meeting that is designed primarily for consideration of problems that affect nurses and nursing, provincially and nationally, and plans for future action.

Recommendations Regarding Employment of Nurses

Recommendations regarding salaries, hours of duty, living and working conditions for nurses were approved at the Executive Committee Meeting, C.N.A., November 20, 1943, and sent out for guidance in the provinces. Recognized as important factors in the stabilization of nursing service, it is urged that these be made the subjects of study and action by joint committees of provincial registered nurses associations and hospital associations. It is realized that, in many instances, additional financial support will be necessary in order to effect salary adjustments and other recommendations. Members of the Executive Committee, C.N.A., expressed the opinion that nurses' oganizations should be ready

to give every support to requests for the necessary financial aid.

Salaries, Increments and Status: The following recommendations regarding salaries, increments and status were approved:

(1) That general duty, or staff, nurses be paid a salary of $1200 per annum for the first year of service, $1260 for the second year and $1320 for the third year. (2) That head nurses be paid a minimum salary of $1380 per annum, and supervisors $1500 per annum.

"Head nurse" to be interpreted as a nurse in charge of one ward and "supervisor" a nurse in charge of two or more wards, or of a department. A recommendation was included that an appropriate *annual* increase for satisfactory service be made for both head nurses and supervisors.

The above salaries were recommeded to apply in situations in which nurses live out. However, it is understood that meals taken while on duty and laundry will be provided at the expense of the hospital; also that salary increases will date from the day of original appointment. It is further recommended that the term "permanent employment" be made applicable to nurses who have given three months of satisfactory service and who signify their intention of continuing in the position.

Hours of Duty: The recommendations regarding hours of duty already made by the Special Committee, C.N.A., were reaffirmed, viz: "that the hours of duty be eight per day for a six-day week, *exclusive of meal hours*; the hours of duty to be consecutive when possible".

Educational Directors and Instructors: The Executive Committee of the Canadian Nurses Association also approved the following resolution that:

Whereas it has been shown that inexperienced and young instructors cannot give the student nurses the type of teaching required to produce good bedside nurses; and whereas it is essential to keep teachers in this field, be it resolved: that the Canadian Nurses Association executive committee ask all directors of schools of nursing to review the salaries and status accorded the educational directors and instructors in their institutions, with the idea of bringing these two factors into conformity with the salaries and status accorded the administrative staff.

Directors of schools of nursing and of other institutions employing educational directors and instructors will realize that the matters dealt with in the foregoing resolution are ones of vital importance in any educational programme.

Health Insurance

Notification has been received from the Canadian Medical Association of a meeting on Health Insurance to be held in Toronto on January 28, 1944, to which the Canadian Nurses Association is invited to send a limited number of representatives. It is stated that the purpose of the conference is to permit the exchange of ideas on those topics which are of mutual interest to a number of groups who are to be represented at the conference, also to afford an opportunity to study some of the major problems that must be faced in connection with health insurance. It is hoped that deliberations at the conference may serve as a further guide for special studies on health insurance that nurses throughout Canada should now be making.

It is planned that a whole session at the general meeting, C.N.A. in June, 1944, is to be given to the study of health insurance and nursing service. Provision is also being made for a meeting of provincial representatives to be held in advance of this session.

Committee on Epidemics

A conference was called in Ottawa on December 3 and 4, 1943, by Dr. T. H. Leggett, chairman of the Committee on Epidemics, Canadian Medical Association. There was wide representation at this meeting including authorities in the Armed Forces; the Department of Pensions and National Health and delegates from national organizations, both professional and lay, concerned with community health and welfare. The chairmen of provincial committees also attended. On behalf of the Honourable the Minister of Pensions and National Health, Dr. R. E. Wodehouse welcomed the delegates and emphasized the value of the conference.

Upon special invitation, the President of the Canadian Nurses Association and the National Adviser attended all sessions of the conference.

The importance of being prepared and the need for comprehensive planning and organization to meet any emergency were stressed. Representatives of the Canadian Nurses Association assured those present that nurses throughout Canada would be prepared and hold themselves in readiness to meet any special calls.

It is felt that the following information will not only be of definite value to nurses in making plans to meet an emergency, but that members of the profession will realize their responsibility in sharing this with all other groups who are interested and concerned in the control of epidemics and maintenance of public health.

The meeting opened with addresses from experts in special fields including data which indicated the dangers that are inseparable from wartime conditions and emphasized the need for intelligent preparation, including preventive measures, to overcome any outbreak of disease which commonly follows in the wake of war.

Special Resolutions: At the close of the sessions resolutions were passed emphasizing the need for immediate mobilization and organization of all personnel, both professional and lay, and of all other resources to assist the health authorities in order to be prepared to cope with any national emergency.

It was decided that practical application of organization should be provincial, with the national committee functioning as a co-ordinating body, all groups concerned working in close co-operation with and complementary to the contributions by the Departments of Health of the various governments.

Provincial Organization: To effect provincial organization, the immediate use by provincial bodies of the following suggestions was recommended, namely:

1. That each urban and rural area throughout the province form a unit of organization.

2. That lists be made of:

(a) all doctors and nurses available, the list of nurses to include all trained nurses outside of active nurses (retired, married, etc.), also so-called "practical nurses" and others willing to take duty, whole or part-time, in case of emergency. It is realized that the Victorian Order of Nurses and other similar nursing organizations will be invaluable in many localities as centres for organization of nursing services.

(b) All trained help, such as St. John Ambulance Home Nursing Divisions, V.A.Ds., Voluntary Nursing aides, stretcher bearers and Red Cross workers; all other available helpers for homes or hospitals among lay groups. It was recommended that study

should be made of additional training that might be given to workers in the latter group.

(c) Automobile drivers and helpers available for transportation of supplies, fuel, food, medicines, patients to hospitals, nurses to points of duty.

3. That a survey be made of buildings that could be used for emergency hospitals and of beds, cots, bedding, cooking equipment, etc. that might be made available.

4. That arrangements be made for (a) patrols prepared to visit every home in order to find those in special need of assistance; (b) retaining of personnel and organization of Civil Defence.

5. That a study be made (a) of what the service clubs and other lay agencies are able and willing to do; how the Navy, Army and Air Force personnel, both professional and lay, and the police and fire department personnel, could be used; (b) of the way in which the radia con be use to used to best advantage. It is suggested that possibly the most effective means of distributing information to the publice is through newspapers and pamphlets.

6. That, as epidemics spread along the lines of travel, a study should be instituted and all plans laid for curtailing travel to the absolute minimum at the earliest threat of epidemic disease.

7. Because the condition of sections of the Indian population, (such as malnutrition, overcrowding and exposure) render them particularly vulnerable to epidemics with attendant abnormally high death rates, therefore, the National Committee recommended that the needs of Indian communities in the face of an epidemic be kept in mind by provincial committees.

For the effective implementation of these suggestions relating to provincial organization, it is recommended that committees be formed to carry out all the above mentioned surveys and studies and to work in close co-operation and with complete understanding of each other's duties; that all efforts be conducted with full knowledge of and in complete harmony with the various departments of health, and that the results of all surveys and studies be framed into one whole co-ordinated plan of action.

The Canadian Medical Association has appointed from its members, chairmen of provincial committees. It is understood that these chairmen have undertaken to be responsible for provincial organization. Representatives of the registered nurses associations have been appointed in each province. Therefore, it is anticipated that information regarding developments related to nursing service will be made available through the provincial associations of registered nurses, or special committee to whom these responsibilities may be delegated.

While the lists of nurses prepared as a result of the general registration carried out in March, 1943, will be made available through the National Selective Service offices throughout Canada, it was pointed out that this is only one means of securing names. To be of value, lists must be revised frequently and kept up-to-date.

At the meeting of the Executive Committee, C.N.A., held in November, 1943, the opinion was expressed that the responsibility of keeping up-to-date lists of nurses available for emergency should rest with the Departments of Health. However, it is understood that each provincial association of registered nurses will agree upon some policy to

cover this important item. It is suggested that the individual nurse, especially those not actively engaged in nursing, may assist in the suggested provincial organization by making her availability for any emergency known if, and when, this information is requested.

Those who attended the meeting held in Ottawa were reminded that health authorities now feel that the dreadful tragedies of the 1918 epidemic might have been averted by thorough organization and efficient preparation *in advance* of the outbreak. Nurses, as members of an enlightened profession, have a special responsibility in supporting such organization and in disseminating information that will aid in securing the cooperation of an informed public.

Teaching First-Aid and Home Nursing

Professional organizations in Canada have endorsed the principle that nurses must accept responsibility for the future of nursing. The Executive Committee of the Canadian Nurses Association points out that this includes giving professional guidance to lay organizations. Furthermore, that the teaching of First Aid and Home Nursing classes for the two national voluntary organizations, namely: the St. John Ambulance Association and the Canadian Red Cross Society, is one way in which this guidance should be effected. Since the outbreak of war, the Canadian Nurses Association has urged nurses to prepare themselves for this responsibility. Directors in Schools of Nursing are also asked to secure for students the initial preparation, in order that they may qualify as soon as possible after graduation.

Personnel at National Office

Early in January of this year, Miss Electa MacLennan reported as an assistant in National Office. This completes the personnel in National Office as decided upon by the Executive Committee, Canadian Nurses Association, at the meeting held in June, 1943. Both the most recent appointees, Miss Florence H. Walker and Miss Electa MacLennan, are well known to a number of nurses across Canada; a hearty welcome is extended to them as members of the staff in National Office.

Welcome News

This Christmas brought glad news to the nurses of Canada. Early in December came a reassuring message of the rescue of Canadian Nursing Sisters who were on a vessel torpedoed while en route to the theatre of war; also of the courage with which the nurses met this ordeal. The Canadian Nurses Association learnt, too, with real joy of the repatriation of nurses from the Orient. Circumstances did not permit of a demonstrative welcome, but nurses in Canada share the happiness that the return of these nurses brought to many hearts and homes.

To be permitted to have even a small share in relieving the burden which fellow members in foreign lands have carried for many months is a privilege sought by the Canadian Nurses Association. Assistance through the British Nurses Relief Fund, a fund built up by nurses in Canada, by personal donations, is offered most gladly for this and similar purposes.

The R. N. A. O. Annual Meeting

The annual meeting of the Registered Nurses Association of Ontario will be held in London, Ontario, from April 12 to 14 inclusive. An interesting programme is in preparation and a large attendance is anticipated.

STUDENT NURSES PAGE

A Student Nurse on Ambulance Duty

MARY E. HUBERT

Student Nurse, School of Nursing, Soldiers Memorial Hospital, Campbellton, N. B.

Following a most interesting lecture on a nurse's responsibilities when called for ambulance duty, I was filled with enthusiasm and was anxiously waiting my turn. One day, just as I had returned from my hours off duty, I was told that my call had come. My heart seemed to flutter but I felt that it was a great opportunity and tried to recall all that I had learned about what a nurse should do.

First of all, she must procure a complete history of the onset, signs and symptoms of the present illness, as well as a history of any previous diseases. This information is obtained by talking with the mother and recording the main points on an ambulance duty slip. This proves valuable to the doctors when making a diagnosis and compiling their case histories. During her conversation with the parents, she must strive to gain their confidence and thus to establish a firm link between home and hospital. It is gratifying to see how parents leave their children in our keeping with apparent confidence and trust. The mother is told of various measures that are taken to safeguard her child, the other patients in the hospital, and the community at large. A list of regulations is left in every home in which may be found the telephone number of the hospital so that the parents may feel free to ask for information. The student nurse's final duty is to check over with the head nurse all data concerning the patient and the many helpful hints obtained while talking with the mother. If the patient is an infant, she should have found out what formula he is getting and what the feeding hours are. Information about the child's habits, and his various ways of expressing himself, are also most helpful in caring for him.

When she arrives at the home, the nurse asks the mother to undress the child and thus has an opportunity to examine him. After the child has been dressed in a hospital gown the ambulance driver rolls the patient in a blanket provided for the purpose. The student nurse is taught that, as far as possible, she must refrain from touching anything in the home; she thus lessens the chance of contracting infection, thereby protecting herself and others.

My patient's home was in an apartment building that housed three families. When we entered, the first thing that struck me forcibly was the attitude of a neighbour who said in a gruff, rude manner "It's not here, it's *always* in there" and proceeded to point down a narrow hall-way. We found ourselves

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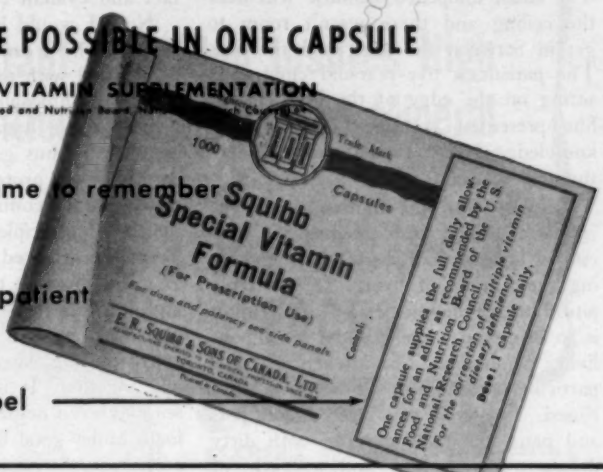
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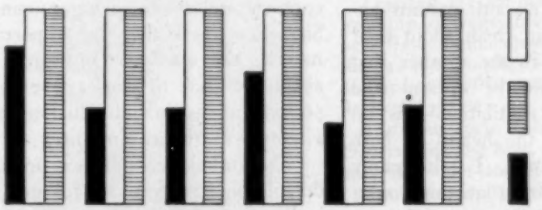

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in a very congested room containing a high chest of drawers and a studio couch pulled out and made into a double bed. The small unopened window was near the ceiling and there wasn't room to get in between the chest and the bed. The patient, a five-year-old child, was sitting on the edge of the bed, crying. She presented a true picture of the knowledge I had gained from the lectures on scarlet fever.

I spoke with the mother about the child's condition and obtained the necessary information meanwhile observing their mode of living. It was truly pitiful to see how extremely difficult it is to bring up a child under such poor living conditions. The kitchen was not particularly clean and the windows were closed. The stove was littered with pots and pans, the table covered with dirty dishes, a cereal box, and a bottle of milk. Several pairs of old shoes were thrown into a corner and the cupboard was most untidy. Yet both parents appeared to be neat and clean about their person. I suggested to the mother that both windows should be opened and stressed that good ventilation was an important factor in the health of both herself and her family. I felt keenly that it was wonderful that this young couple could make ends meet and hope for betters days. They seemed deeply devoted to each other and their little one.

I am sure it is with a rather bewildered anxiety that a family sees a loved one pass into strange hands even for medical attention and nursing care. However, a kind word and gentle touch from the attending nurse quickly dispenses this justifiable sense of uneasiness. She comes into close contact with patients in all walks of life whether they be people of means or poor unfortunates in humbler districts. Although some people find it disconcerting to see an ambulance speeding down the street with its siren whining and wonder whether anyone is in attendance. On discovering the nurse seated beside the patient, their alarm is assuaged because of her calm dignity, tact and evident efficiency.

Now I would like to mention a few reasons why I am glad that my School is affiliated with the Alexandra Hospital for Communicable Diseases. Here we are taught the basic principles of medical asepsis and thus gain knowledge, which enables us to protect ourselves, our patients, and the community at large. Once the basic principles of medical asepsis have been acquired, one is able to improvise and to carry them out under other and less favourable circumstances. We also learn how to teach the patient the art of playing, laughing and living happily together. It is really gratifying to see how even neglected children blossom forth under good living conditions, skilled nursing care and guidance. The student nurse sees and helps to direct the child's growth and training in her daily contacts and while giving nursing care. She comes to realize the importance of nursing the *whole* patient—not merely as another case of scarlet fever but as a person and as an individual member of a family in the community.

The ambulance call gave me a wonderful opportunity to see for myself how less privileged people are sometimes obliged to live. This experience may prove to be a deciding factor for me as to what I shall do after graduation—I think it will be public health nursing. What could be more interesting than to help these poor people solve such difficult problems? My ambulance duty also helped me, after I returned to the ward, to understand the children much better and to realize what a wonderful institution a communicable disease hospital is. It is, in itself, a school of learning of hygiene for these unfortunate children. I am selfish enough to hope that I shall have an opportunity to go out on another ambulance call before my affiliation term is over.

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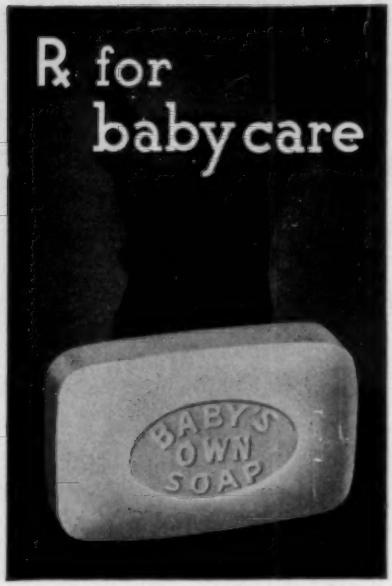

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PRODUCTS

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

The following nurses, having completed two months' period of orientation in Victorian Order nursing, have been posted to various branches as follows: *Katherine Weatherhead*, Kitchener; *Ella Johnson*, Timmins; *Dorothy Clements*, Pictou; *Dorothy Chard*, Sherbrooke; *Edith McKerlie*, Saskatoon.

Elizabeth J. Hicks, a graduate of Toronto East General Hospital, has been appointed temporarily to the East York staff.

Cora Mansfield, a graduate of Orillia Soldiers' Memorial Hospital, has been appointed temporarily to the Timmins staff.

Mrs. Olive Weese, a graduate of Children's Memorial Hospital, has been appointed temporarily to the Belleville staff.

Mrs. McIntyre (Adele Campbell), previously on the Montreal staff, has returned to the Order and has been appointed to the Victoria staff.

Evelyn M. Hunter, a graduate of Saint John General Hospital, has been appointed temporarily to the Saint John staff.

Phyllis Archibald, a graduate of Saint John General Hospital, has been appointed temporarily to the Truro staff.

Margaret C. McIntosh has resigned from the Pictou staff and is on leave of absence from the Victorian Order of Nurses for Canada.

Margaret Payne has resigned from the Truro staff and has accepted a position as general secretary with the Children's Aid Society.

Ruth Priddle has resigned as nurse-in-charge of the Arnprior Branch.

Elizabeth Ferguson has been transferred from the St. Catharines staff to take charge of the Arnprior Branch.

Muriel Rice has been transferred from the Kirkland Lake Branch to take charge of the Yarmouth Branch.

Dorothy Lemery has been transferred from the staff of the Saskatoon Branch to take charge of the Kirkland Lake Branch.

Scholarships – A Community Project

There must be many towns and small cities throughout Canada where nurses meet and put their heads together to work out schemes for assisting Canada's war effort — in nursing, as well as in other fields. Invariably they encounter the problem of financing. How can they raise sufficient money to carry out their plans? The nurses of Brandon were no exception, but we feel gratified in having been able to carry one project through to a successful conclusion, and we are anxious to pass on our experience to others.

Last winter, the Brandon Graduate Nurses Association decided to attempt the raising of funds for a scholarship in teaching and supervision in schools of nursing or in public health nursing. Immediately the question arose as to how the plan could be financed. We reasoned that, since nursing is a community interest, we would be justified in contacting outside groups for help. Our problem was presented to the local branches of the Kiwanis, Kinsmen, and Lions Clubs, as well as to the medical faculty of the Brandon General Hospital. All these groups were tremendously interested, and responded generously. Although our own nurses' association raised the major portion of the total amount, the task was comparatively easy when we realized that we had the support of the citizens of Brandon.

Our first scholarship student, Eleanor Bray, will commence her university work in the fall, and will return to Brandon when her course is completed. We feel that by initiating this piece of work we are helping to raise the standard of nursing in our own community.

Viewed by itself, this is a relatively small enterprise; however, if a similar plan were tried in a number of towns and small cities throughout our Dominion, there would be many more qualified instructors for our nursing schools and many more public health nurses for our rural districts.

MRS. C. NORMANSELL BURN

Chairman, Scholarship Committee
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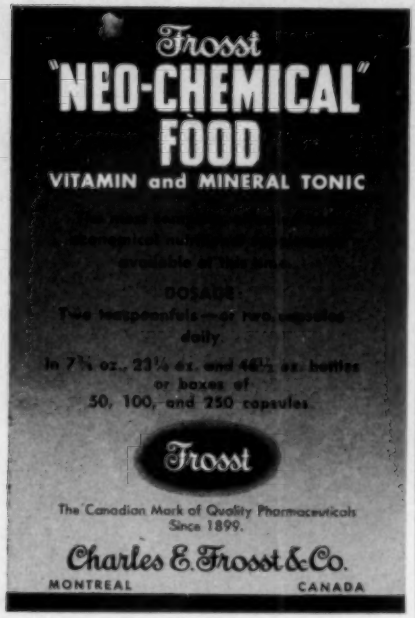

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New Year's Honours

It was very gratifying to find that the New Year's Honours List included the names of a number of nurses who are now serving their country with the Fighting Forces. Hearty congratulations to all of them!

The Royal Red Cross (First Class) was awarded to: Major Nancy Kennedy-Reid (principal matron); Major Dorothy MacRae (principal matron); Major Dorothy Riches (principal matron); Major Edna Rossiter (principal matron); Captain Margaret Crawford (matron).

The Royal Red Cross (Second Class) has been awarded to: Captain Grace Paterson (matron); Captain Margaret Smith (matron); Lieutenant Rose Hamelyn (nursing sister); Lieutenant Dorothy Macham (acting captain, acting matron); Lieutenant Marguerite MacLean (nursing sister); Lieutenant Anne Thorpe (nursing sister).

Bouquets

The A.A.R.N. and the A.R.N.P.Q. have both adopted the bright idea of awarding a year's subscription to the *Journal* to students taking the R.N. examinations who achieve unusually high standing. The response of the lucky recipients has been most enthusiastic. Vera Maile, who is now in England, has this to say:

It was with very great pleasure that I received a letter telling me that *The Canadian Nurse* is to come to me as a gift from the Association of Registered Nurses of the Province of Quebec. It will certainly be a link with Canada for me and I am sure that the other nurses who are over here will enjoy seeing it too.

Every now and then our readers put new courage into us by saying a good word for the *Journal*. The other day Miss Jean Gordon of Winnipeg wrote us as follows:

After an absence of nearly six years I have recently returned to active nursing. I find the *Journal* not only interesting but also beneficial because some of the case

studies reported upon were similar to those I have had to nurse.

And here is a word from an Albertan public health nurse, Miss Amy Conroy:

I have always found the *Journal* very helpful and appreciate the effort that has been made to make it worthwhile.

Meeting in the Maritimes

The *Journal* is indebted to Miss Ruth Wilson, secretary of the Maritime Hospital Association, for sending us a printed report of its first annual meeting which gives a most interesting account of what was evidently a very stimulating occasion. The meeting was held in Kentville and the large attendance included many nurses. Dr. George F. Stephens and Dr. Harvey Agnew represented the Canadian Hospital Council and took a prominent part in the lively debates that were a feature of every session. One of the principal speakers was Mr. R. F. Cahalane, chairman of the Council of Public Education of the American Hospital Association and director of the Blue Cross Hospital Plan for Massachusetts. Health insurance came in for a large share of attention as did wartime rationing.

Nursing problems were certainly not overlooked and a very able report of the committee on nursing was presented by its chairman, Miss Marjorie Jenkins, president of the Registered Nurses Association of Nova Scotia. Besides reporting fully upon the measures taken to meet the situation in the Maritime Provinces, Miss Jenkins also gave an excellent picture of the part that the Canadian Nurses Association and its provincial units have played in maintaining an adequate nursing service during these difficult years.

There is no better way of promoting harmonious relationships between the hospital and nursing groups than by holding meetings of this kind. They afford an opportunity for friendly and informal contact that leads to the ironing out of all sorts of misunderstandings between people who are mutually dependent upon one another for the success of their common task. It certainly looks as though the Maritime Hospital Association was off to a good start.

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NEWS NOTES

BRITISH COLUMBIA

The Powell River Chapter of the R. N. A. B. C. has "adopted" twelve nurses in England who were aged, needy or had been bombed out. Two parcels were sent each month. So far every parcel has reached its destination and the letters from the recipients have been most gratifying. Some of their stories are very sad, telling of losing their homes in air raids. The intention of the chapter is to carry on in this manner for the duration.

NEW BRUNSWICK

MONCTON:

The Moncton Chapter, N.B.A.R.N., met at the Moncton Hospital recently with the president, Miss A. J. MacMaster, presiding. Plans for raising money during the coming year were discussed. A report from the sale of tickets on a beautifully dressed doll, presented by one of the Chapter members and won by one of the patients in the hospital, was given by Miss Breau. The Chapter also contributed money toward a gift fund for children who were in hospital at Christmas.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

DISTRICT 1

CHATHAM:

Miss Debby Hooper was elected president of the Public General Hospital Alumnae Association at the annual meeting held recently. Officers for 1944 are: honourary president, Miss Priscilla Campbell; vice-presidents, Mrs. Herbert Goldrick, Anne Bell; recording secretary, Jean Stobbs; corresponding secretary, Margaret Gilbert; assistant, Katherine Burgess; treasurer, Mrs. George Symes; social committee, Luella Smyth, Helen McClure; press convener, Winifred Fair; shopping committee, Mrs. W. J. Renouf, Mrs. S. McCann, Mrs. W. Taylor; representative to *The Canadian Nurse*, Mrs. Don Nicholls; refreshment con-

vener, Mrs. James E. Harrington; assistant, Mrs. James Stoeher.

The retiring secretary stated, in a report covering the activities of the past year, that ten regular meetings had been held with an average attendance of 15. Delegates attended three district meetings and also the annual meeting of the R.N.A.O. Complimentary memberships were given former members now serving overseas.

Donations were made to the Russian Relief, the Chinese Relief, the Red Cross, the Chatham V. O. N., the Contingency Fund of the R.N.A.O., and to the Greek Relief.

Members assisted in teaching home nursing classes with the making of Red Cross surgical supplies and at the blood donors clinic. It was announced that the loan fund started during the past year for the purpose of furthering post graduate education is being used this year by one of the members.

District 6

The following officers were recently elected by the Alumnae Association of the Belleville General Hospital: president, Mrs. A. E. Miles; first vice-president, Nita Bush; second vice-president, Mrs. J. Bean; secretary, Grace Donnelly; treasurer, K. Brickman; flower and gift convener, M. Bonter; social convener, B. Braumont; program convener, M. McIntosh; *The Canadian Nurse* and press representative, Margaret Plumton.

QUEBEC

Montreal:

Royal Victoria Hospital:

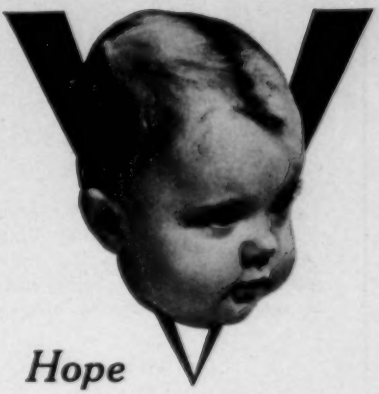
Our congratulations go to Matron Christine Crawford, Chorley Park Military Hospital, Toronto, Principal Matron Dorothy Riches, Headquarters staff, London, and Matron Margaret A. Smith, No. 6 C.C.S., whose names appeared in the New Year's Honours List. Principal Matron Riches and Matron Crawford were awarded the R.R.C. and Matron Smith the A.R.R.C.

Jessie Cameron, Helen McLeish, Helen Perryman and Sara Powell are taking a course in psychiatry at the New York Psychiatric Institute. Dr. S. Ewen Cameron is giving a course of lectures in psychiatric nursing to the graduate staff. Patricia Raymond has left for the Boston Children's Hospital to take a course in pediatrics. Doris Russell is in charge of Ward G (men's surgical). Mary Allison Prescott is spending the winter months in Montreal.

Edith Green, B.A., led the Province, and Elizabeth Hebb came second, in the recent R.N. examinations.

McGill School for Graduate Nurses:

Victoria Antonini (T. & S., 1941) has resigned from the staff of the Regina General Hospital and is now serving with the R. C. A. M. C. Willa Ahern (P.H.N., 1936), now with the R.C.A.M.C., was a recent visitor to the School



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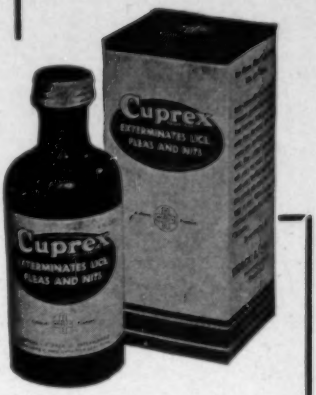

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COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

Numerals indicate office held: (1) *President, Provincial Nurses Association;* (2) *Chairman, Hospital and School of Nursing Section;* (3) *Chairman, Public Health Section;* (4) *Chairman, General Nursing Section.*

Alberta: (1) Miss Ida Johnson, Royal Alexandra Hospital, Edmonton; (2) Miss Gena Bamforth, Royal Alexandra Hospital, Edmonton; (3) Miss Jean S. Clark, City Hall, Calgary; (4) Miss Gertrude M. B. Thorne, 332-21 Ave. W., Calgary.

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Nova Scotia: (1) Miss M. Jenkins, Children's Hospital, Halifax; (2) Sister Catherine Gerard, Halifax Infirmary; (3) Miss Jean Forbes, 412 Tower Rd., Halifax; (4) Miss M. Ripley, 46 Dublin St., Halifax.

Ontario: (1) Miss Mildred I. Walker, Institute of Public Health, London; (2) Miss Dora Arnold, Brantford General Hospital; (3) Miss Winnifred Ashplant, 807 Waterloo St., London; (4) Miss Stella Murray, Niagara-on-the-Lake.

Prince Edward Island: (1) Miss K. MacLennan, Provincial Sanatorium, Charlottetown; (2) Miss Anna Bennett, P.E.I. Hospital, Charlottetown; (3) Miss Ruth Ross, Summerside; (4) Miss Dorothy Greenan, 15 Grafton St., Charlottetown.

Quebec: (1) Miss Eileen Flanagan, 3801 University St., Montreal; (2) Rev. Soeur Décary, Notre Dame Hospital, Montreal; (3) Mlle Marie Cantin, 4352 St. Denis St., Apt 3, Montreal; (4) Miss Effie Killins, 3533 University St., Montreal.

Saskatchewan: (1) Miss M. R. Diederichs, Grey Nuns' Hospital, Regina; (2) Miss Ethel James, Saskatoon City Hospital; (3) Miss Mary E. Brown, 5 Bellevue Annex, Regina; (4) Miss M. R. Chisholm, 805-7th Ave. N., Saskatoon.

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General Secretary, Miss K. W. Ellis, National Office, 1411 Crescent St., Montreal, P.Q.

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